



Care Management Organization Policy Manual

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Foreword

The Care Management Organizations (CMO) in New Jersey are broadly responsible for coordinating supports and services for youth with moderate and high needs and their families, ultimately helping them feel better. They are responsible for removing barriers to care and supporting the development of a sustainable long-term plan that allows youth and families to succeed in managing their needs by coordinating and accessing supports and services, they identify.

The New Jersey Department of Children and Families, Division of Children's System of Care (CSOC) has revised the Care Management Organization Manual to offer minimum standards of operation to which CMOs must adhere to and that reflect current CSOC policies and practices in CMO service delivery. Care Management Manual is reflective of best practice and is grounded in the wrap around model and system of care approach.

This manual cannot account for every specific situation that will arise during Care Management services. However, the underlying premise that Care Management practice upholds the best interest of the youth and family as planned for through the child family team (CFT) collectively can support any circumstance, including the importance of language.

CSOC is grateful to the many local system, technical assistance and state representative partners that provided language, resources, time and effort into the conceptualization and development of this manual. This process was a true collaboration.

Section 1: System of Care History and Guiding Principles

I. System of Care History

Children's advocates had long identified a need for fundamental structural reform of New Jersey's System of Care for child, youth, and young adults (youth) with emotional and behavioral health needs and their families. Initially, like virtually every other state, a number of youth-serving systems, each with its own mandates, perspective, and priorities, had responsibility to serve these youth. Youth and families entered services through many different doors (child welfare, mental health, juvenile justice, education, and the courts), often with similar needs for behavioral health and other community support services. The access route generally defined the problem and the services available. This, in turn, tended to define treatment goals and objectives based on the mandates and priorities of the specific youth serving system. The available services within these systems were then organized as programs, requiring youth to fit the program's structure rather than structuring supports and services to meet the individual needs of the youth and family.

In November 1999, New Jersey was awarded a System of Care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Burlington County, establishing the Burlington Partnership.

In 2000, New Jersey (NJ) began a major statewide reform initiative to restructure the system for delivering services to youth with behavioral health needs and their families utilizing a System of Care approach, coordinated and integrated at the local level, and focused on improved outcomes for youth and their families. The NJ Children's System of Care adopted the Wraparound Model using the Child Family Team Process. Wraparound is a team based planning process that brings together people from different parts of a family's life to help families reach their goals and vision. Wraparound is characterized by a set of Core Values and guiding Principles. The NJ Children's System of Care is founded on the following Core Values and Principles:

a. System of Care Approach

- Family Driven and Youth Guided– Families are engaged as active participants at all levels of planning, organization, and service delivery.
- Culturally and Linguistically Competent – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
- Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

b. The Principles of Wraparound

1. Family Voice and Choice
2. Team Based

3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent
7. Individualized
8. Strength Based
9. Unconditional
10. Outcome Based

These Principles, including methods of implementation, are described and practiced in the NJ Wraparound: Values & Principles Training, and are reinforced through supervision.

Through the implementation of these Values and Principles, we can ensure that our practice supports the best possible outcomes. Some of the outcomes that the System of Care strives for and that are supported by this implementation are:

- Improved emotional stability for our youth
- Youth remaining in their communities
- Reduced OOH lengths of stay
- Reduced acute psychiatric hospitalization readmissions
- Improved ability for caregivers to provide stable living environments for our youth
- Improved educational performance and overall social functioning for our youth
- Reduced legal involvement for our youth

By 2006, the System of Care had been fully implemented in every New Jersey County.

Recognizing the continued need for improvement within a System of Care is essential as the need for mental health services by those youth within the child welfare system continually grows; NJ's System of Care (CSOC) has continuously sought to improve services and supports.¹

New Jersey is one of the only states whose child welfare reform plan included a statewide restructuring that resulted in the creation of a specific department to house all youth and family based structures. The Department of Children and Families (DCF) in July 2006 became the first cabinet level agency whose mission was devoted exclusively to serve and safeguard the most vulnerable youth and families in the state.²

Included in DCF was the Division of Child Protection and Permanency (DCP&P, formerly known as DYFS) and the Division of Children's System of Care (CSOC, formerly known as DCBHS), as well as other divisions and entities. The mandate of CSOC was to serve youth with

¹ McGill, K., & McGill, S.A. .New Jersey Children's Behavioral Healthcare System: Cross service delivery planning for transitional population of youth (ages 16 and 18 + years). Evaluation and Program Planning (2010), doi:10.1016/j.evalprogplan.2010.11.008

² McGill, K., & McGill, S.A. .New Jersey Children's Behavioral Healthcare System: Cross service delivery planning for transitional population of youth (ages 16 and 18 + years). Evaluation and Program Planning (2010), doi:10.1016/j.evalprogplan.2010.11.008

emotional and behavioral health care needs and their families. DCP&P's primary mandate was investigating and protecting youth from abuse and neglect while also working towards securing permanency for youth without primary caregivers.

The creation of DCF resulted in a new DCP&P Practice Model that would ensure better planning and coordination between DCP&P and CSOC. Throughout 2006 and 2007, CSOC continued to seek input through focus groups, public hearings, and an independent assessment from the University of South Florida to address improvements to the system. During 2007 and 2008, and based upon the major recommendations received, CSOC began the process of implementing a thorough plan for these system improvements. As a further evolution of the System of Care, Youth Case Management, which served moderate need youth, and Care Management, which served high need youth, were unified to provide streamlined services through a single entity.

Further reorganization and realignment of service delivery in DCF began in July 2012. Services provided to youth with developmental disabilities and intellectual disabilities were transferred from the NJ Department of Human Services' Division of Developmental Disabilities (DHS/DDD) into the DCF's Division of Children's System of Care (CSOC). Addiction services for adolescents up to age 18, and those ages 18-21 already under the protective supervision of the Division of Child Protection and Permanency (DCP&P) or receiving behavioral health services through CSOC, were transferred from the DHS Division of Mental Health and Addiction Services (DMHAS) to DCF.

Effective July 1, 2013, DCF's Contracted System Administrator (see Section 2) began authorizing youth who meet specific criteria to receive substance use treatment (SUT) services from a limited number of providers who are contracted with DCF/CSOC. In January 2014, CSOC expanded adolescent substance use treatment resources to include the South Jersey Initiative (SJI) as well as detoxification services for adolescents.

In 2015, SAMHSA awarded DCF a \$12 million grant to introduce two trauma-informed interventions: Six Core Strategies for Reducing Seclusion and Restraint Use, and the Nurtured Heart Approach. These strategies were put in place to: reduce the percentage of youth in the System of Care who require multiple episodes of out-of-home treatment; reduce the percentage of youth who re-enter treatment after transition from an initial treatment episode; reduce the average length of stay for youth in out-of-home treatment; and, analyze and understand the impact of each type of system investment in order to make future resource allocation decisions.

The Concept Paper that served as a basis for the beginning of the NJ Children's System of Care is available at:

<http://www.nj.gov/dcf/about/divisions/dcsc/Childrens.Initiative.Concept.Paper.pdf>

Section 2: Components of the Children's System of Care

The Children's System of Care includes a broad array of services to support the needs of youth with behavioral health, substance use, and intellectual/developmental challenges. All supports and services offered through CSOC are grounded in System of Care approach and are driven by the values and principles of Wraparound. All services within CSOC are voluntary and require parent/guardian consent. Youth under 18 years of age are not required to provide written consent, although engagement of youth in the services is necessary for a successful intervention.

I. Contracted System Administrator (CSA)

The CSA serves as the single point of access to services for NJ youth up to age 21 (18 for certain substance use services) with behavioral, emotional, intellectual, developmental, and/or substance use needs. The CSA connects youth and their families with the care they need at the right intensity of treatment.

The CSA also facilitates and supports utilization management (including service planning), care coordination, quality management, and information management for the statewide system of care. In this administrative support role, it provides DCF, the CMO, and other system partners with the information needed to manage the care planning process toward quality outcomes and cost effective treatment. They are also responsible for housing and maintaining the electronic health record (EHR) for each youth served by CSOC.

Access to Services: The Triage Process

The CSA maintains a toll free statewide number that families may call to access NJ CSOC Services. Upon contact from a family, the CSA will complete a registration process during which a youth's information will be entered into the CSOC's EHR. The family will speak with a Care Coordinator who is a licensed clinician. The Care Coordinator will obtain information from the family to assist in identifying the right path to meet a youth and family's needs.

If the CSA is called in an emergency, the caller will be connected directly with a trained clinician. That person will ask questions to best determine how to help. A behavioral emergency is any serious behavior on the part of a youth that, if not dealt with right away, could lead to the youth or someone else being harmed. Depending on the emergency, the caller may be referred to their local hospital psychiatric screening center, or, in a serious emergency, the caller will be directed to reach emergency personnel by calling 9-1-1. If the youth is screened at an emergency room or is hospitalized, the caller or the youth's treatment team can request other supports from the CSA to help when the immediate emergency is over.

In urgent behavioral situations (where a person's immediate safety is not at risk but a youth's behavior is escalating beyond a parent or caregiver's ability to manage it), families are connected to their local Mobile Response and Stabilization Services (MRSS) provider. MRSS

responds to the crisis in person, within one hour from the family's call to the CSA. See below for more details on the services provided by MRSS.

In situations where there is a need for more information than can be collected over the phone in order to make an accurate assessment of the youth's needs and the most appropriate resources or services to offer, the CSA will authorize a Needs Assessment and Biopsychosocial evaluation (Needs/BPS) by a licensed Intensive In-Community (IIC) provider. See Section 6 for more information on IIC services.

For more information on the current CSA, see <http://www.performcarenj.org/about/index.aspx>.

A Youth and Family Guide to CSOC and the CSA is available in English online at <http://www.performcarenj.org/pdf/provider/youth-family-guide-eng.pdf>.

A Youth and Family Guide is available in Spanish online at <http://www.performcarenj.org/pdf/provider/youth-family-guide-span.pdf>.

II. Mobile Response and Stabilization Services (MRSS)

MRSS is the CSOC's urgent response service designed to assist in stabilizing youth in their home and community settings. MRSS provides immediate intervention to assist youth and their caregivers in de-escalating behaviors, emotions, and/or dynamics impacting youth life functioning. Interventions are designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains. MRSS is available 24 hours a day, seven days a week within an hour of a family's request to help youth who are experiencing emotional or behavioral crises. NJ relies on a family's definition of a crisis as the standard for defining what constitutes a crisis and thus precipitates an offer for MRSS services. The MRSS initial dispatch offers face-to-face service delivery to families in the community at the site of the escalating behavior, whether this is the youth's home or another living arrangement, including resource and foster family homes. The initial phase of MRSS can extend for up to 72 hours after the dispatch request and includes de-escalation, assessment, and crisis planning services with a focus on youth and family engagement. The Crisis Assessment Tool (CAT) is completed based on the assessment to inform a comprehensive Individualized Crisis Plan (ICP).

Based on the youth and family's needs following the 72 hour initial response, MRSS may remain involved with the child and family for up to eight weeks of stabilization management, during which time MRSS staff will coordinate formal and informal services for the youth and family. MRSS staff will work with the youth and family during this time to ensure a proper transition plan is in place at the end of the youth and family's stabilization period.

Service areas in New Jersey may choose to operate a Combined MRSS-FCIU program, which follows the MRSS program model and comports with the FCIU statutes and standards. More information on FCIU is available in Section 8.

More detail on MRSS is available at <http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-72-hrs.pdf> and <http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-8-wks.pdf>

III. Family Support Organizations (FSO)

FSOs are nonprofit, county based organizations run by families of youth with emotional, behavioral, developmental, and/or substance use challenges who have received services from any youth serving system. FSOs allow caregivers to benefit from the guidance and support of other caregivers with similar experiences. FSOs provide direct family-to-family peer support, education, advocacy, and other supports to caregivers of these youth in partnership with the CMO. To access services, families may call these organizations directly or call the CSA.

Caregivers of youth involved with the CMO have access to a one-on-one certified Peer Support Partner who will help them navigate the System of Care, school system, DCP&P, and the legal system. Peer Support Partners are certified through the State of New Jersey's approved curriculum. Peer Support Partners are also available to provide moral support as needed. The FSO assists families in identifying and accessing sustainable natural supports in their communities. Caregivers are empowered to be active, informed, and strong advocates for their youth. The FSO engages families in the community, helping them to identify their strengths and building on those strengths to address their needs and goals.

Both caregivers of youth involved in the CMO and youth with emotional and behavioral needs who are not involved with the CMO are offered a variety of supports and services, including, but not limited to:

1. Warmline during business hours
2. Support groups
3. Educational workshops
4. Youth Partnerships
5. System Collaboration

A list of FSOs and their contact information is available at <http://www.nj.gov/dcf/families/support/support> .

a. Youth Partnerships

Youth Partnerships are peer support groups for youth affiliated with each FSO. They provide a variety of local events and opportunities for teens and young adults with behavioral health challenges, whether or not they have been involved in CSOC services. Youth Partnerships help youth develop self-advocacy and leadership skills, and work to reduce the stigma attached to having a behavioral health challenge or diagnosis. Meetings often occur weekly or monthly, depending on the service area.

Youth Partnerships statewide met with CSOC to develop standards around youth voice in system development and service delivery. In 2008, the Youth Guiding Document was published with their recommendations. That document is available at http://www.nj.gov/dcf/documents/behavioral/YCguidingdoc10_28_09.pdf

Additional youth development resources are available at <http://www.nj.gov/dcf/providers/csc/>.

IV. Care Management Organizations (CMO)

CMOs are county based, nonprofit organizations that are responsible for face-to-face care management and comprehensive service planning for youth and their families with intense and/or complex needs. They coordinate Child Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and his/her family. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to planning.

The CMO's role is to help families to feel better by developing a plan to address their needs and removing barriers that may impede progress. Their goal is to help youth and families develop a long term, sustainable plan that will support them in improved functioning long after CMO involvement. The CFT does anything necessary to remove barriers to care, drive care in the SOC approach, and facilitate creative, flexible planning to support the family and youth.

Initial CMO services include, but are not limited to:

1. Engagement of the youth and family into CMO services
2. Initiate development of Child Family Team including collaboration with FSO
3. Development of a Family Crisis Plan to stabilize the youth and address the immediate concerns of the youth and family

Continuing CMO services include, but are not limited to:

1. Comprehensive assessment services
2. ISP design and implementation
3. Advocacy and family support
4. Monitoring, Information management and improvement

In addition to the above, CMOs are the designated Behavioral Health Home (BHH) entities for youth in New Jersey. BHHs serve as a “bridge” that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high-end services.

The BHH Core Team, which includes medical and health/wellness expertise, builds on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team constitutes the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

V. Children’s Inter-Agency Coordinating Councils (CIACC)

CIACCs are local planning bodies that foster cross-system service planning for youth with behavioral health needs. CIACCs provide a multidisciplinary forum to develop and maintain a responsive, accessible, and integrated System of Care for youth with social, behavioral, developmental, substance use, and/or emotional needs and their families, through the involvement of families, youth, natural family supports, and youth serving agencies as partners.

CIACCs serve in an advisory capacity to both county government and DCF in planning for services for youth. They are facilitated by a local CIACC Convener funded through CSOC, and their membership includes families, local system partners (including CMOs), community based organizations, county planning entities, and state representatives. They identify needs and address barriers to effective service delivery, and make appropriate recommendations on programs and policies to ensure a comprehensive system of needed services within the county is maintained. They also participate in ongoing DCF quality assurance processes.

The CIACC Manual is available at <http://www.nj.gov/dcf/documents/behavioral/providers/CIACCmanual.pdf> .

A list of CIACC Conveners is available at <http://www.state.nj.us/dcf/providers/resources/interagency/> .

See Section 8 for more information on coordination with CIACCs and other system partners.

Section 3: Care Management Organization Structure

I. The Role of the Care Management Organization in the Community

CSOC established and funded CMO agencies statewide to coordinate care for youth with moderate to high, complex needs and their families to support youth in remaining at home, in school, and in the community. CMOs contracts were awarded through a Request for Proposal process and are governed by regulations, which can be found at N.J.A.C. 10:73 Subchapter 3.

CMOs are the single point of organizational accountability for developing the local system of care necessary to support need based intervention and achieve desired outcomes for youth with behavioral health, developmental, or substance use challenges, whose ties to home and community are threatened. CMOs must demonstrate commitment and capacity to organize an effective system of care at the community level that builds on strengths and effectively addresses needs.

System of care development happens on both the system and individual levels. CMOs are responsible for helping families to identify and develop a network of support for each family consisting of natural supports, informal community supports, and formal service supports. This requires both identifying existing supports and integrating them into the system of care, and developing new supports based on the needs, culture, and values of the youth and families served.

Developing an organized, integrated system of support on an individual level is done through the development of Child Family Teams (CFT). The CFT model provides the structure for families, with support from the CMO, to identify, develop, and organize both community and formal supports specifically designed to help the family meet their unique needs and culture.

II. CMO Executive Leadership

The executive leadership of the CMOs includes both the Chief Executive and the Board of Directors. The Chief Executive and Board of Directors are mutually accountable to each other for the successful fiscal stability and operations of the CMO. Executive Leadership must report any changes to management staffing or other significant staffing event as per contracting requirements outlined in the DCF Contract Policy and Information Manual and in accordance with N.J.A.C, 10:73-3.

a. Chief Executive

The CMO Chief Executive oversees all components of the CMO and ensures implementation of all components of the CMO's mission. The CMO was established as the local leadership of the Children's System of Care, with the CMO Executive serving as a leader in community development. The Chief Executive represents the CMO in relation to system partners, providers, and community groups. The Chief Executive represents the System of Care in

articulating and applying its values and principles in collaboration with other youth-serving systems within the CMO's service area.

The Chief Executive leads the agency in operationalizing the practice model in Care Management, community resource development, and organizing the major functions of the CMO to deliver services that ensure the needs of youth are met according to the Wraparound Model.

III. Board of Directors: Structure, Formation, and Governance

The Board of Directors (BOD) is responsible for ensuring that the CMO fulfills its mission to provide quality Care Management and community resource development. The BOD has the responsibility for the adequate overall governance of the CMO, including maintaining the financial health of the CMO, and the development of corporate and agency policies. Board members serve as ambassadors of the CMO and the System of Care in their activities in the community.

The Board of Directors is charged with the responsibility of ensuring the CMO agency work is reflective of the CSOC promulgated mission, values, and principles. They have the fiduciary responsibility to ensure all resources dedicated to the organization are used to support youth with complex needs as described in regulations and policy. Regulations governing Care Management Organizations are available at N.J.A.C. 10:73. The Board is responsible to stakeholders, particularly the local families and communities. The BOD selects and appoints the Chief Executive to carry out the agency's mission and oversee its operations. The Board is required to review and evaluate the Chief Executive's performance regularly on the basis of their job description, including executive relations with the board, leadership in the organization, program planning and implementation, and management of the organization and its personnel. The BOD offers administrative guidance and determines whether to retain or dismiss the Chief Executive.

CMO Board of Directors must be reflective of the racial and ethnic composition of the communities they serve and must include representatives from the community and family members whose youth are current or past recipients of the existing systems serving this population. Membership of the CMO Board of Directors must include a minimum of 1/3 family members whose children are current or recent recipients of system services and not exceed 1/3 of service providers for the system population.

The corporate by-laws must include the following provisions:

- A Chief Executive is an employee of the Board, and shall not maintain a seat on the Board or serve as an officer of the Board
- All members will assume active board responsibility for the CMO and will not represent the interests of any other provider organization in this capacity
- Board members may not be employees of service providers that may be brokered, purchased, or procured by the CMO unless that Board member clearly discloses their professional relationship and signs a conflict of interest form indicating they will recuse

themselves from decision making in which they have a real or perceived personal or financial interest

- A quorum can be no less than 50% membership
- Defined policies regarding conflict of interest

IV. CMO Functional Roles

Job titles at individual CMOs may vary, but all CMOs include staff to provide basic functions. Each CMO has an employee manual, which outlines the job titles and functions specific to that CMO. Regulations governing CMOs include minimum required experience, degrees, and qualifications for CMO staff.

CMO core functions include:

a. Management

i. Operations

The Operations Manager provides leadership, vision, supervision, and motivation to the care management staff, and ensures that the care management operations support and enable adherence to the organization's mission, goals, and objectives. This person also provides leadership and vision to system partners to foster a collaborative system of care to meet the individualized needs of youth.

ii. Financial

The Financial Executive is responsible for providing financial leadership in the attainment of the agency's mission. The Financial Executive assists in the development of strategic financial plans and budgets, assists in the development of annual business goals, and acts as a resource to the agency regarding all fiscal matters. The Financial Executive is also responsible for managing the Fiscal/Business Office functions, and for the preparation and integrity of the agency's financial statements. The Financial Executive works with the DCF Contract Administrator on matters of a fiscal nature. The Financial Executive assists the agency's external auditors to prepare an annual audit and advises the Executive and Board on financial and business matters.

iii. Community Resource Development

The Community Resource position is responsible for providing leadership in the broad attainment of the agency's mission. This person is responsible for planning, directing, managing, and implementing a comprehensive community resource development system on behalf of the CMO. The Community Resource position is responsible for planning, developing, and implementing a timely, accurate, and comprehensive resource database for use by Care Managers and key stakeholders throughout the community. The Community Resource position is responsible for planning, developing, and implementing strategies to effectively communicate the mission of the CMO, and solicit

support from the county and community to develop and expand needed resources through participation in local CIACCs. The Community Resource position is also responsible for coordinating service identification and linkages.

The Community Resource position may also be involved in planning and conducting resource development training. The Community Resource position is responsible for developing a comprehensive, detailed process for soliciting, approving, and monitoring resource development funds awarded to community organizations for activities that advance the mission of the CMO.

iv. Quality Assessment/Performance Improvement

The role of Quality Assurance/Performance Improvement is to develop and implement a Quality Assessment/Performance Improvement (QAPI) plan to ensure that the organization is adhering to regulatory standards from DCF and NJ FamilyCare as well as local goals and objectives. To accomplish adherence to the QAPI plan and regulatory standards, the staff analyzes, and reports on various data sources to demonstrate compliance and track trends and identifies areas of organizational improvement to align with best practices. QA/PI staff provides oversight on or supports efforts in compliance, privacy, and security of protected health information and unusual incident reporting requirements to the state. QA/PI staff work closely with their local Management Teams, with their counterparts in the state, and with the CSA Service Desk staff and EHR developers, to improve data tracking and reporting on both an organizational and a systems level with a goal of informing practice changes that support performance improvement. Information on current EHR data reporting capability is located at <http://www.performcarenj.org/provider/training/performcare-presentations.aspx>. The primary focus for the QA/PI position is to work toward the CMO organizational mission and ensure that youth and families achieve positive outcomes as a result of their involvement with the CMO.

b. Care Management

i. Care Manager Supervisor

The role of Care Manager Supervisors is to provide direct supervision to Care Managers (CM) in their work with youth and families. Supervisors ensure that Wraparound Model values and principles are infused throughout care management practice and that CMO staff are engaging and supporting families and implementing the CFT process as outlined towards the goal of maintaining quality service delivery. Supervisors are responsive to CM needs and provide feedback to CMs regarding CFT facilitation and process and adherence to the wrap around model. They are responsible for supervising assessment and care planning processes, developing collaborative problem solving across youth serving systems, and managing complex system dynamics in the community.

CMOs ideally maintain a 6:1 CM to CM Supervisor ratio.

ii. Care Manager

The Care Manager (CM) is the primary representative of the CMO to the youth, families, natural supports, and providers. CMs are responsible for engaging the youth and family in the care management service and CFT process, and developing and facilitating the CFT to ensure assessment and planning for youth and family's needs. The CM upholds the agency's commitment to coordinate and provide strategies, supports, and services that are family centered, community based, strengths based, individualized, culturally competent, and easily accessible.

CMOs ideally maintain, on average, a 14:1 youth to CM ratio.

c. Clinical Consultant to DCP&P

The role of the Clinical Consultant is to provide clinical expertise and recommendations for youth and families under the care of DCP&P that have behavioral health needs. The Clinical Consultant supports and encourages a treatment philosophy of working with families in a strengths based model. This is a model of service that embraces the philosophy that youth are best served in their homes and in their communities, using the Wraparound Model and the CFT planning process to build natural and informal supports and maximize coordination of supports and services across systems.

d. Behavioral Health Homes (BHH)

BHH staff provide health and wellness activities for the youth and their families with the ultimate goal that the youth and families develop the skills and ability to actively manage the youth's chronic medical as well as behavioral health condition. BHH staff includes a Nurse Manager and a Health and Wellness Coach.

i. Nurse Manager

The Nurse Manager participates in the CFT for BHH assigned youth and contributes to the development of self-management health goals on the ISP. They facilitate the engagement of youth and families in community supports which may include preparing youth and families for pending appointments and accompanying youth and families on appointments to reduce apprehension, and assist assigned families with identifying a primary care provider and attending annual well visits and all applicable early period screening. They provide health education and promotion to youth and families according to their individual needs, obtain applicable metabolic levels and information for assigned youth from primary care providers, and facilitate regular contact with the youth and families to monitor progress and provide support for the self-management goals included in the ISP.

Ratio: 1 Nurse Manager for up to 40 youth

ii. Health and Wellness Coach

The Health and Wellness Coach participates in the CFT for BHH assigned youth and contributes to the development of self-management health goals; engages youth and families in health promotion planning and activities; provides health education specific to the chronic conditions of assigned youth; and, engages youth and families in community supports which may include preparing for pending appointments and accompanying youth and families on appointments to reduce apprehension.

The Health and Wellness coach is responsible to facilitate regular contact with the youth and family to monitor progress and provide support for the self-management goals included in the ISP. They are also responsible to collaborate with the Nurse Manager to identify, monitor, and report outcome measures and participate in transitional care and follow-up planning to ensure sustainability.

Ratio: 1 Health and Wellness Coach for up to 65 youth

V. Other Roles

Across the 15 CMOs, other roles may exist to meet the needs of the individual service area. These roles may include, but are not limited to:

- Court Liaison
- Presumptive Eligibility Coordinator (PE Coordinator)
- Care Manager Lead/Senior Care Manager
- Program Manager
- System Coordinator/Liaison

VI. Care Manager Certification

All Care Managers must be certified according to CSOC guidelines. Statewide certification guidelines are currently in the process of being developed, and will include 3 elements: training attendance (or education equivalency), core competencies, and an online review.

The CSOC Training and Technical Assistance Program will provide the trainings and maintain the online certification tracking system for the CMOs, including the online review. Care Manager Supervisors will assess and track their Care Managers' training attendance and core competencies, and work with Care Managers who need to take the online review more than once. All Care Managers will be required to be certified within 1 year of their date of hire, and to be recertified annually.

Time frames and specific elements of the CMO Care Manager Certification process will be available on the Training and Technical Assistance Program website at <http://www.nj.gov/dcf/providers/csc/training/>.

VII. Documentation

CMO must maintain verification that all supervisors and staff providing direct services are certified in the use of the CSOC Strengths and Needs Assessment (SNA) IMDS Tool prior to

their use of such tools, and must be recertified annually. Additional documentation, such as current driver's licenses, successful completion of criminal background checks, current clinical licenses if applicable, etc., must also be maintained by the CMO, as outlined in the regulations governing CMO services, which is available at N.J.A.C. 10:73.

Section 4: Access and Eligibility

I. Pathways to the CMO

There are several ways a family may be referred to the CMO from the CSA, depending on the intensity of their needs and their primary need. Regardless of the source of the referral, a family must agree to be an active participant in CMO services. A family's request for services through the CSA provides initial consent for those services provided based on the family's assessed needs. No matter the source of referral, the information submitted is reviewed by CSOC's CSA to see if the youth being referred meets CMO clinical criteria. If a youth does meet the CMO clinical criteria, they will be assigned to the county in which their caregivers/guardians, including DCP&P if applicable, reside. Should a family request to be assigned to a neighboring county/service area CMO, the referral entity, family, and CMO agencies will coordinate the family being assigned to the neighboring CMO with the CSA.

a. Needs Assessment/Biopsychosocial Assessment (Needs/BPS)

If a family calls the CSA and there is a need for more information than can be collected over the phone in order to make an accurate assessment of the youth's needs and the most appropriate resources or services, the CSA will authorize a Needs/BPS. A licensed IIC clinician will go out to the family's home and conduct the assessment, then provide the CSA with the results of the assessment and recommendations for the intensity and modality of services needed by the family. If the IIC finds that the family has a moderate to high intensity of need in more than one life domain, they will include in their recommendations that the youth and family can benefit from help with coordinating services and supports. The CSA will review the assessment information, and if the CMO clinical criteria are met, the family will be referred to the CMO.

Needs/BPS Guidelines and Requirements are available at <http://www.performcarenj.com/provider/behavioral/resources-faq.aspx>.

b. MRSS Referral

If a family involved with MRSS needs continued care management and support based on the youth's high or moderate needs, MRSS will explain Care Management to the family, and make the recommendation to CSA to refer the family to the CMO. MRSS will document the youth's need for the CMO level of service and submit a CMO service request via the EHR to the CSA for review. The CSA will review the information and if the CMO clinical criteria are met, the family will be referred to the CMO. MRSS will reach out to the CMO to let them know of the youth being referred and to coordinate the transition process from MRSS to CMO. These processes will be developed locally and may include an initial joint meeting with MRSS, CMO, and family where necessary.

c. Existing Clinical Providers

If a family is seeing a provider in the community, such as an outpatient therapist, that provider has developed a relationship with the youth and family and gathered information relevant to the youth's needs. Should the provider feel the youth's needs are moderate to high and include a need for coordination of multiple services across more than one life domain, he or she can refer the family for CMO services through a Clinical Summary Template, which is submitted to the CSA.

The CSA reviews the Clinical Summary Template and determines the Intensity of Service (IOS) need of the youth. If the youth meets the clinical criteria for the CMO, the CSA will assign the youth to the CMO in his/her community.

d. Court Referrals, including 14 Day Plans

CSOC and the Court systems have developed identified mechanisms for youth involved with Family Court who present with behavioral, emotional, or mental health needs to access assessment and coordination of supports and services.

When a youth comes to the attention of the court due to juvenile delinquency or family matters and presents with behavioral, emotional, or mental health needs, the court has several options for accessing assessments of the youth needs:

The preferred method of access to assessment and services through CSOC for court involved youth with identified emotional or behavioral health needs in the community is for the court personnel to have the family contact the CSA to arrange a Needs/BPS as described above.

When a youth's needs are not clear, the court may order an assessment of the youth's strengths and needs to inform service needs. This assessment is facilitated by the CMO and is known as a 14 day plan. These assessments are most useful when ordered at the initial indication of potential behavioral health needs, and not at the time of legal disposition.

The 14 Day Plan FAQs can be found at <http://www.nj.gov/dcf/providers/csc/index.html>.

e. Youth Detention Centers

All youth remanded to a juvenile detention center (JDC) will be screened for behavioral health needs through the administration of the MAYSI (Massachusetts Youth Screening Instrument), and (in some counties) for developmental needs through the DD Screening Tool, whether CMO is involved or not. If the MAYSI reveals further assessment is needed for behavioral health concerns, the JDC social services will request a BPS through the CSA. If the DD Screening Tool reveals further assessment is needed for developmental concerns, JDC social services will request a BPS through the CSA with a DD Specialty IIC provider. Once the JDC requests a BPS, the CSA will authorize the Needs/BPS to be completed within 5 days of the request by an identified assessor specialized in providing such at detention centers. A Needs/BPS may also be requested by the youth's attorney or caregiver if the youth is on psychotropic medications, or a youth has a history of multiple arrests for the same behavior. The JJC Best Practice Guidelines can be viewed at <http://www.performcarenj.org/provider/behavioral/resources-FAQ.aspx>.

f. Substance Use Assessors/Providers

Families may call the CSA to request a specialty substance use Needs/BPS. An IIC provider will assess the youth, and submit the Needs/BPS to the CSA, who will use the Needs/BPS to inform the IOS determination. If a youth meets the clinical criteria for CMO services, the CMO will assign the youth to the CMO in his/her community.

Substance use service providers can refer to the CMO in one of two ways. They can provide a specialty substance use BPS assessment to youth who present at their facilities. The substance use treatment provider will submit the BPS to the CSA for IOS determination. If the youth meets the criteria for CMO services, the CSA will enroll the youth in the CMO in their community.

Upon admission to a substance use OOH treatment program, youth are automatically enrolled in the CMO. Substance use treatment providers will engage with the family to obtain the Substance Use Treatment Consent Form necessary to complete the enrollment.

g. Children's Crisis Intervention Services (CCIS)

A youth who is admitted to a CCIS unit who has moderate to high needs, including a need for coordination of multiple services across more than one life domain, may be referred to the CMO once the CCIS conducts a Needs Assessment (NA). The CCIS will submit the NA to the CSA, who will review the NA and determine the Intensity of Service (IOS) need of the youth. If the youth meets the clinical criteria for the CMO, the CSA will assign the youth to the CMO in his/her community.

h. Juvenile Justice Commission (JJC)

At the time of transition out of a JJC program, youth may be referred to the CSA to ease their transition back to the community. The JJC service provider will complete a NA and submit it to the CSA, who will review the NA and determine the Intensity of Service (IOS) need of the youth. If the youth meets the clinical criteria for the CMO, the CSA will assign the youth to the CMO in his/her community.

i. Cross County Referrals

A youth involved in a CMO who relocates to another service area in NJ will be referred to the CMO in their new county of residence. The CMOs from both the youth's previous county of residence and the youth's new county of residence will coordinate transition to the new CMO at the supervisor and/or administrative level.

II. CMO Eligibility Requirements

The CMO serves youth with emotional and behavioral health needs, developmental or intellectual disabilities, and substance use needs, or any combination of these needs.

To be eligible for CMO services, the youth must meet the following criteria:

- a) The youth is between the ages of 5 and 21. Special consideration will be given to youth under age 5 or over 21.
- b) Youth demonstrates moderate to severe emotional or mental health challenges consistent with a DSM 5/ICD 10 diagnosis, which adversely affects his or her capacity to function adequately in significant life domains such as family, school, community, social, or recreational/vocational. When the etiology of the symptoms is unclear (behavioral health vs. developmental/intellectual disability), an assessment describing the youth's functional capacity within school, home, and the community, as well as his/her ability to think or perceive surroundings accurately and interact appropriately with others demonstrates that the youth's functioning can be improved with the provision of CSOC services.
- c) The CSOC Assessment and other relevant information indicate that the youth needs care management provided by a CMO and requires service coordination and linkages such as with specialized behavioral health services or medication management services, and coordination with Child Study Teams, other school personnel, DCP&P, adult services, Juvenile Detention/Justice, and/or medical health services. The CSOC assessment and other relevant information indicates a decline in the youth's baseline functioning or demonstrates that the youth's functioning can be improved with the provision of CMO services.
- d) The youth and his/her family require face to face assistance in obtaining or coordinating treatment, rehabilitation, medical, financial, and/or social services, without which the youth could reasonably be expected to require more intensive service to improve or maintain functioning in the community.
- e) The persons with authority to consent to treatment for the youth voluntarily agree to participate. The consent of a youth who is not authorized under applicable law to consent to treatment is desirable, but not required.
- f) The youth must also either: demonstrate at risk behaviors or other psychosocial factors which place him/her at increased likelihood for Out of Home (OOH) treatment or psychiatric hospitalization; be awaiting OOH treatment; have recently been transitioned from a CCIS, other inpatient psychiatric hospitalization, or other institutional or residential community based treatment program, and is returning to a community setting; have multiple episodes of inpatient psychiatric hospitalization or other institutional or residential community based treatment program within the past 12 months;
- g) Youth with an intellectual or developmental disability in the absence of a co-occurring mental health challenge, may be exempted from b) above, but must additionally meet the following criteria:
 - youth has been determined DD eligible by CSOC (or previously determined eligible by DDD)
 - youth manifests moderate to severe behavioral challenges and skill building needs resulting in a high to moderate level of functional impairment which adversely affects his or her capacity to adequately function in significant life domains, such as family, school, community, social, or recreations/vocational activities.

Full clinical criteria for CMO services are updated regularly, and are available at <http://performcarenj.org/pdf/provider/clinicalcriteria/cmo-high.pdf> or <http://performcarenj.org/pdf/provider/clinicalcriteria/cmo-moderate.pdf>.

III. Additional Supports and Services Available to CMO Youth

Youth who are in need of CMO services and intensive care coordination may have additional supports available to them to help stabilize and support the youth and family. Additional supports for the youth may include specialized services from the CMO, including Behavioral Health Home (BHH) Services and Social Emotional Learning Services (SEL).

a. Developmental Disability (DD) Eligibility

Some youth enrolled in the CMO may present with developmental needs and may not yet have a determination of DD eligibility. In these instances, the Care Manager should support the family in making an application for DD eligibility through CSOC. Care Managers can connect families with advocacy groups such as the FSO, ARC, Autism NJ, Mom2Mom, etc. Additionally, Care Managers may request an expedited review of a complete eligibility application with supporting documentation through the CSA Service Desk. The CSA Service Desk can be accessed through their email address: servicedesk@performcarenj.org. The Application for Determination of DD Eligibility for Children Under Age 18, Citizenship and Residency Requirements, and the Readiness Checklist for DD Eligibility, is available on the CSA website at <http://www.performcarenj.org/families/disability/determination-eligibility.aspx> for youth up to their 18th birthday. Families who don't have access to the internet can call the CSA and request an application to be mailed to them.

For youth ages 18 to 21 who have not had a DD eligibility determination made but could benefit from DD services, applications for DD eligibility must be made to the Division of Developmental Disabilities (DDD) at <http://www.state.nj.us/humanservices/ddd/services/apply/index.html> in order for them to receive services from DDD after 21. CSOC is responsible for providing services to individuals between the ages of 18 and 21 once they have a determination of eligibility. Eligibility for services from CSOC extends up to and includes the day before an individual's 21st birthday. Special consideration may be given to youth beyond their 21st birthday.

Further information on services for DD Eligible youth are available at <http://www.performcarenj.org/families/disability/index.aspx>.

DD eligible youth who are also eligible for NJ FamilyCare have access to a Managed Care Organization (MCO) care manager who can assist with coordination of benefits.

b. Behavioral Health Homes (BHH)

A Behavioral Health Home is a planning process, not an actual dwelling. Eligible youth have access to additional medical expertise and support needed for a holistic approach from the CMO. A Nurse Manager and a Wellness Coach are added to the youth's CFT to assist in facilitating both primary care and behavioral healthcare. Youth may be determined eligible for BHH upon initial referral to CMO, or BHH can be requested by a CFT once the youth is enrolled in CMO.

If the CFT determines that BHH services are appropriate for the youth based on the clinical criteria and the family agrees to participate (opt in), the CM will document in a CFT note how the youth meets the clinical criteria and assessment, including diagnostic information, that the youth has NJ FamilyCare coverage, and that the family has consented to the service. BHH services must be requested through ISP process, and reviewed and approved by the CSA. When BHH services are approved and authorized, the BHH service authorization includes both BHH and CMO services.

In order to receive BHH Services, a youth must meet each of the following qualifications:

- CMO Criteria
- Youth is under age 21
- Youth is presently active with NJ Family Care
- Youth is diagnosed with eligible covered chronic health condition (*criteria to be posted on CSA website*)
- Youth has a need for additional care management services to coordinate behavioral and physical health, such as:
 - Youth needs help adhering to the prescribed treatment plan for his/her chronic health condition
 - Youth demonstrates poor coping in managing his/her chronic health condition
 - Youth and/or family is experiencing barriers to accessing care for his/her chronic health condition
 - Youth demonstrates a pattern of over- or under-utilization of services for his/her chronic health condition
 - Youth and/or family is experiencing challenges in managing the daily care required for his/her chronic health condition
- Youth's caregiver(s) reside in a county where BHH services have been initiated
- Youth and family agree to participate in BHH services

Youth will be excluded from receiving BHH services if he/she has an open case with DCP&P and is presently in a resource home, or was transitioned from an out of home placement or treatment setting within the past 30 days and is being monitored by the DCP&P Child Health Unit. CMO must coordinate with DCP&P (if family is in agreement) to determine if BHH through CMO is more appropriate than involvement with Child Health Unit for youth in out of home treatment programs through CSOC.

Any of the following criteria is sufficient for transition out of BHH services (while continuing to receive CMO services):

- Youth lost eligibility for NJ FamilyCare and will be transitioned on the last day of the month
- Youth has achieved his/her service goals for BHH
- Youth and/or family decline continuation of BHH services
- Youth has partially achieved his/her service goals for BHH and has received the maximum benefit

Note: All other exclusionary, continued stay, and transition criteria for CMO applies. The goal of DCF-CSOC is to see the BHH initiative implemented statewide. DCF-CSOC is rolling out BHHs through a county by county process. Information related to the BHH initiative found in this manual and the attached appendix is relevant only to those counties where a federally approved State Plan Amendment allowing BHH services is valid.

Please see Appendix E: Behavioral Health Homes

More information can also be found at <https://www.chcs.org/resource/customizing-health-homes-for-children-with-serious-behavioral-health-challenges/>

c. Social Emotional Learning (SEL)

Social Emotional Learning (SEL) is a set of two services: Youth Support and Training, which targets youth ages 5-16, and Transitional Youth Life Skill Building, which targets youth ages 16-21. To be eligible for these services, a youth must be enrolled in the CMO, and meet the continued stay criteria for CMO.

Additional services will be available in the future, including Non-Medical Transportation. Additionally, a Medical Service Package for youth who are not NJ FamilyCare eligible.

IV. Coordination of Insurance Coverage

Some families at the time of enrollment in CMO have already been found eligible for NJ FamilyCare (the State health benefits program), some families have private health insurance, and other families have no insurance coverage. For youth to receive the most comprehensive supports and services, CMOs must identify all available resources, including all insurance benefit availability. All youth and families not currently eligible for NJ FamilyCare are required to complete the NJ FamilyCare Presumptive Eligibility (PE) process and, if found eligible, the full NJ FamilyCare application process. Youth in out of home are not screened for PE.

CMOs, as enrolled NJ FamilyCare Presumptive Eligibility (PE) providers, consistent with all requirements of N.J.A.C. 10:49-2.8, are required to assist the family in all aspects of applying for PE/NJ FamilyCare coverage. This includes, but is not limited to:

1. Assisting families to engage in applying for health benefits

2. Explaining to the family the importance of providing health benefit coverage to their youth and any other eligible beneficiary in the home
3. Assisting families in the application process, including providing documentation and access to transportation to related appointments as needed, and providing advocacy by contacting the eligibility determination agencies on the family's behalf

CMOs assist families/individuals in completing the NJ FamilyCare application prior to seeking approval for accessing any services funded with public state funds. Any delay or inability of staff to process the application could result in delayed access to CSOC services.

CMs are responsible to describe the application process to the family. As part of the NJ FamilyCare PE Process, CMs are required to gather information on any existing private insurance the family may have. CMs should educate families to help them understand why it is necessary for them to complete the application process and share their private insurance information.

a. NJ FamilyCare PE Provider Responsibilities

All CMO providers are required to:

- Enroll as a PE Provider with DMAHS
- Assure that Care Management staff and other appropriate staff complete the DMAHS PE training
- Designate a PE Coordinator and a backup PE Coordinator at the CMO
- Complete a PE application for each youth who is not otherwise covered under NJ FamilyCare at the time of the referral to the CMO, if the PE process has not already been initiated by another entity within 7 days of referral to CMO
- Submit all PE applications to DMAHS
- Assist the youth and/or his/her family in collecting the documentation required to complete and submit a NJ FamilyCare application within 30 days of enrollment, if this process has not already been initiated by another entity
- As family circumstances indicate, review eligibility factors for each beneficiary and assist the beneficiary and/or his/her family in applying for any and all benefits for which they may be eligible, including, but not limited to NJ FamilyCare
- Assist the beneficiary and/or his/her family in maintaining eligibility for NJ FamilyCare and other benefits, including working with the family in accessing new eligibility within 2 weeks of the last day of previous coverage. Providers should check the family's eligibility regularly, even if the youth presents a Health Benefit ID (HBID) eligibility card or if they have previously provided services to ensure that the eligibility status of the youth has not changed.

Once a PE/NJ FamilyCare has been filed, the CMO and family will be notified of the eligibility determination. All records supporting determinations of eligibility or ineligibility made in accordance with this section must be maintained by the CMO and available for audit.

Once youth are found eligible for NJ FamilyCare, they will be assigned to the appropriate program, and may be prompted to select a NJ FamilyCare Managed Care Organization. Some youth qualify for special programs, of which CMOs should be aware for coordination of care.

i. **MLTSS and DDD Waivers**

Youth who qualify for the Managed Long Term Supports and Services and the DDD Community Care Waiver cannot be simultaneously enrolled with the CMO. If a CMO enrolled youth is part of one of these programs, the CM must reach out to the Managed Care Organization (MCO) or DDD Care Manager respectively to coordinate planning for the youth.

b. 3560 Eligibility (CSOC's Medicaid Look-Alike)

For youth found ineligible for NJ FamilyCare, CMs are required to assist the family in applying for 3560 eligibility to access CSOC services. 3560 eligibility provides coverage for specified services when the youth is not eligible through other sources. The CSA is responsible for the review and eligibility determination for 3560 applications submitted by PE entities. A 3560 application will not be considered until a youth or family is determined ineligible for NJ FamilyCare. A letter of denial for NJ FamilyCare coverage will be required in certain instances.

3560 eligibility covers behavioral health services as indicated below:

- Mental/Behavioral Health Screening, Evaluation, and Diagnostic Services
- CSOC Designated Multi-System Assessments
- Care Coordination by a CMO
- MRSS Services
- Inpatient Psychiatric Hospital Services provided by certain psychiatric hospitals
- Partial Care/Partial Hospitalization
- Intensive In-Community Services
- Behavioral Assistance Services
- Mental Health Clinic Services
- Outpatient mental health services, including psychiatric, psychological, or advance practice nurse services, individual, group, and family therapy provided in either a practitioner's office, a clinic, or an outpatient department of a hospital
- Medication Management/Monitoring
- Out of Home Treatment, including Treatment Homes, Group Homes, Psychiatric Community Residences, and Psychiatric Residential Treatment Facilities

Examples of youth who are 3560 Eligible include:

- Youth who are deemed eligible for SED NJ FamilyCare
- Youth who are enrolled in SED NJ FamilyCare who subsequently transition to or are authorized for CMO moderate intensity of service and are not otherwise NJ FamilyCare eligible
- Youth who does not have proper documentation of citizenship
- Youth in ID/DD programs with the CSC26 out of home service code

- Youth who have a gap in NJ FamilyCare eligibility

Web training on 3560 is available at www.performcarenj.org/training/performcare-presentations under Billing and Claims.

Generally, NJ FamilyCare is the payer of last resort. This means that other health insurance pays for covered services first, and the NJ FamilyCare Health Plan generally pays for covered services last. CMs should assist families in identifying and accessing available supports and services through their private insurance coverage as part of the CFT planning process.

c. SED NJFC Eligibility

Youth with high needs who are enrolled in a CMO and do not appear to be eligible for NJ FamilyCare and/or are determined ineligible through the NJ FamilyCare application process, may be eligible to apply for SED NJFC. The CM will explain the limits of SED NJFC eligibility to the family as part of the application process. CMOs are required to notify NJ FamilyCare should a youth become ineligible for SED NJFC based on their needs or transition from CMO services.

To access SED NJFC, CMs will follow the SED NJ FamilyCare Eligibility Process for Youth Authorized to CMO (High) as listed below.

Application Process for SED NJFC

The SED NJFC application process is applicable for youth that are CMO high in home/ in the community as well as youth in out of home care setting that are not otherwise NJFC eligible.

- The application for SED NJFC (the NJ FamilyCare Aged, Blind and Disabled (ABD) Programs) can be located on line at <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/index.html>
- Please print and complete the ABD application.
- Send completed application and supporting documentation to the Division of Medical Assistance and Health Services (DMAHS), Operations and Eligibility Unit. The CMO may send the application one of three ways:
- Scan and e-mail: MAHS.CountyOps@dhs.state.nj.us (Preferred Method)
- Mail:
New Jersey Department of Human Services
Division of Medical Assistance and Health Services
PO Box 712-Mail Code 32
Trenton, New Jersey 08625-0712
Attention: Operations and Eligibility Unit
- Fax: (609) 588-2742

The SED NJFC packet must include the following:

- Application
- Supplemental Information (Designation of Authorized Representative Form)
- The CMO authorization letter
- Supporting documentation (copy of the birth certificate, financial information etc.)

- You may not need to submit/not required with the SED NJFC packet the Supplemental Information (Spouse Information Form), unless the youth is married
- Section 3 (Spouse Name) will be blank unless the youth is married

Note: The CMO does not need to wait for the youth to be out of home 30 days to make an application (as with the former HHO process). The process begins when a youth is posted to YouthLink

- Do not submit the application to the County Boards of Social Services. It must go to the State Office (DMAHS, Operations and Eligibility Unit) for review.
- The Operations and Eligibility Unit has up to 45 days to review and make an eligibility determination. CMOs will be notified by DMAHS, Operations and Eligibility Unit of eligibility or ineligibility.
- If eligible, DMAHS will assign a NJFC (Medicaid) number. It will include the program status code (PSC) of 220 with the Special Program Code (SPC) of 37. Youth will be deemed eligible for one year as long as they remain active with the CMO.
- If the youth is deemed SED NJFC ineligible by DMAHS, the CMO will need to submit a 3560 eligibility application in CYBER.
- CMOs must notify DMHAS at MAHS.CountyOps@dhs.state.nj.us once the youth is no longer eligible (is either no longer CMO high after the one year period or transitions out of CMO completely).
- The CSA verifies SED NJFC clinical eligibility by documenting relevant clinical criteria met within a progress note in the EHR. The CMOs will not need to submit medical documentation application.
- The CMO will need to submit financial and other supporting documentation.
- Only one application is required for the SED NJFC. The process is not based on out of home care, or bed size.
- SED NJ FamilyCare eligible youth will receive a Health Benefits ID card (HBID).
- Youth that enter the CMO who are already in out of home treatment, such as SU out of home care, would directly apply for SED NJFC and are not able to apply for PE.

d. Third Party Liability (TPL)

Third party insurance is any private insurance coverage a family/individual may have that can provide access to covered behavioral health services. Through the above processes, a family may also be found eligible for NJ FamilyCare as secondary insurance, or the youth may be

approved for state funds that will cover the cost of certain behavioral health services to supplement private insurance benefits.

Section 5: Care Management Organization Program Model

I. The Wraparound Model

The Care Management Organization model is grounded in CSOC's guiding Values and Principles which are adapted from System of Care (SOC) approach and the Wraparound Model.

Wraparound is an intensive, individualized care planning and management process which brings together the family, the professionals working with the family, and informal and community supports to develop and implement a plan to meet the family's needs. The Wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process which, compared to traditional treatment planning, results in plans that are more effective and more relevant to the youth and family, yielding more sustainability of progress. Wraparound plans are holistic in that they are designed to meet the identified needs of the youth, caregiver(s), and siblings in a range of life areas. Plans focus on skill building, integrating the youth and family into the community, and building the family's social network of supports.

The Wraparound approach begins from the principle of "family voice and choice," which means that the perspectives of the family members, including the youth, are given primary importance during all phases and activities of Wraparound. The Ten Principles of the Wraparound Process from the National Wraparound Initiative is available at [http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-\(10-principles-of-wrap\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf) . This document and more information about Wraparound are available at <http://www.nwi.pdx.edu> .

a. System of Care Approach

- Family Driven and Youth Guided– Families are engaged as active participants at all levels of planning, organization, and service delivery.
- Culturally and Linguistically Competent – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
- Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

b. The Principles of Wraparound

1. Family Voice and Choice
2. Team Based
3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent

7. Individualized
8. Strength Based
9. Unconditional
10. Outcome Based

These Principles, including methods of implementation, are described and practiced in the NJ Wraparound: Values & Principles Training, and are reinforced through supervision.

Through the implementation of these Values and Principles, we can ensure that our practice supports the best possible outcomes. Some of the outcomes that the System of Care strives for and that are supported by this implementation are:

1. Improved emotional stability for our youth
2. Youth remaining in their communities
3. Reduced OOH lengths of stay
4. Reduced acute psychiatric hospitalization readmissions
5. Improved ability for caregivers to provide stable living environments for our youth
6. Improved educational performance and overall social functioning for our youth
7. Reduced legal involvement for our youth

c. Family Friendly Language

Wraparound places emphasis on how communication affects interactions, youth and family engagement, and ultimately, youth and family outcomes. Feedback from youth and families has shown that being respectful of the family voice and expertise includes using language that is natural for the youth and family and is reflective of the Wraparound approach, and not reflective of a more “medical model” which includes technical terms, jargon, etc. Using a common language to discuss youth and family needs respects both the expertise of the youth and other family members, as well as the expertise of providers, both of which are imperative to the process.

Please see Appendix A and B for a chart on family friendly language.

II. NJ Care Management Processes

The National Wraparound Initiative (NWI) outlines 4 phases of Wraparound; Engagement and Support/Team Preparation, Initial Plan Development, Implementation, and Transition. NJ has translated these phases into their Care Management process, which is outlined below.

a. Referral and Engagement

Introduction and engagement between the CM, youth, and family begins at the time a referral is received and communication efforts begin, with attention to the cultural and linguistic needs of the family. CMOs are committed to providing services and ensuring that supports are offered in a language that is comfortable for the family. Learning and incorporating the youth and family's

culture, values, preferences, and interests into the planning process is necessary to tailoring a plan and strategies to address a family's unique and specific needs in a way that makes sense to the family, and allows for a more sustainable plan.

Successful relationship building is a key building block to success in Wraparound, and engagement is at the heart of establishing a relationship. Engagement goes beyond inviting a youth and family to a meeting or to be a part of the process. An engaged family and youth feel the person with whom they are communicating is listening to and understands each of their circumstances and feelings from their perspectives in a non-judgmental or empathic way. CMs utilize a number of interpersonal skills such as attending, actively listening, and reflecting of conversation content and emotion to convey empathy for the youth and family. Meeting the youth and family where they are is an initial step and is important, as it will build trust and allow CM, CFT, youth, and family to discuss challenges openly knowing there is mutual respect. This goal begins with initial outreach efforts after a youth's referral to the CMO and efforts must be continued throughout the youth and family's enrollment.

Upon a youth's referral to the CMO from the CSA, the CMO will assign a Care Manager (CM) to engage with the youth and family per their local process. The CM will make reasonable efforts to contact the family within 24 hours of the referral to arrange an initial face to face meeting with the youth and caregiver(s) at a location identified by the family, most typically the youth and family's home. This meeting will occur within 72 hours from the initial phone contact. Should the family elect to delay the initial meeting, the CMO will document the efforts to schedule within the time frame and the family's request to delay in a progress note.

b. CMO and FSO Collaboration

To insure **the vital collaboration** needed between the CMO and FSO partners, youth and family referred to the CMO are at the same time referred to the Family Support Organization (FSO). CMO Care Managers will coordinate with their FSO partners around the introduction of FSO services to the families, and around initial face-to-face meetings and Child Family Team meetings. Specifics of coordination vary at the local level. It is minimally expected that FSOs will have the opportunity to talk directly with the families about their services and for those families who accept FSO services, CFT meeting dates will be coordinated between CMO and FSO partners, as driven by family choice. If a family initially chooses not to involve the FSO, the CM is expected to continue to offer their supportive services as needs arise. A family may elect to engage with the FSO at any point throughout their CMO experience.

CSOC places great emphasis on the presence of the family voice within the CFT as a necessary component of a youth and family's treatment and success, and expects the FSO's participation with the CM, families, and youth to be a priority when coordinating initial and CFT visits. CMs follow internal procedures for preparing for the first visit, e.g., meeting with the supervisor to discuss safety/risk factors and other relevant circumstances.

c. Initial Face to Face Visit

The initial face-to-face meeting has several purposes:

i. Introducing Care Management

The CMO Care Manager, FSO partner, youth, and family are introduced to one another and CM continues youth and family engagement by beginning to hear the family's story. CMs are expected to support all family members including the youth in sharing relevant information from their perspective. This is the continuation of the engagement process during which the CM invests in relationship and rapport building with the youth and family by listening, reflecting, and being empathic. Engagement and building rapport are processes, and may not be accomplished with all family members during the first visit. CMs should see every interaction as an opportunity to increase engagement with caregivers, youth, and other team members, as this ensures the best opportunity for success.

The CM is responsible for introducing CMO services and describing the System of Care approach, the Wraparound Model, and the Child Family Team process including roles and responsibilities of all involved. The CM should review with youth and families that the CMO service is voluntary and requires certain elements of family participation to continue. The CM should review Wraparound Values and Principles, using family friendly language, and explain how they drive CMO practice. The family's and youth's understanding of their role and of their participation in the process is imperative for positive outcomes.

This informed consent is important in framing the steps of the CFT process and the youth and family's care. Although youth under age 18 are not required to consent for treatment, the CM should engage the youth and help them understand that their voice is important to the process. This process may happen over time and with multiple efforts of the CM attempting different approaches to build rapport and relationship with the youth. The CM will assist the family in exploring and identifying potential CFT members and discuss the goal of expanding the CFT over time to incorporate social and community supports that will build sustainability within the youth and family plan.

The CM will introduce and explain the concept of NJ FamilyCare and the CSOC eligibility process, describe its necessity in relation to CMO enrollment, and provide guidance to the family in the completion of the necessary eligibility forms. This process is required and should be approached in an engaging way.

Release of information for collateral contact information, record access and other documents to be signed by/given to the family may be required as outlined in local CMO procedure manuals. Please see Documentation section below for more information on Release of Information.

ii. Family Crisis Planning

The initial visit includes the CM helping families develop a plan to manage crisis situations related to identified needs. In conjunction with the youth and family, the CM will begin to identify any potential circumstances that may precipitate a crisis for the

youth and/or family. The family's definition of a crisis, as well as risks and triggers that could lead to a crisis are discussed.

The Care Manager and family will together define elements of a supportive crisis plan, which includes, at a minimum:

- What a crisis would be for the family
- Risk Factors and triggers that precipitate crises
- Concrete, functional strategies that reduce the likelihood of or the severity of a crisis
- Resources that may help them in a crisis
- Functional strengths of the youth and family and how they can assist in a crisis situation.

CM should help families identify multiple strategies to use in a crisis situation. The strategies should be specific to the crisis situations identified by the family and include responses to triggers for both youth and the family. The goal of crisis planning is to assist the families with strategies and supports that can be used to respond at the earliest sign of escalation, and to foster and practice skill building that enables the family to move toward managing crises on their own. CM and families will achieve consensus on the plan. Crises occur on a spectrum with psychiatric crisis and imminently life threatening behaviors at the highest level. At the highest level of escalation, psychiatric screening or police involvement should be considered. CMs will outline circumstances for which this level of intervention should be accessed by the family. Otherwise, if the family needs help in crisis, they will follow their crisis plan and reach out to the CM for guidance and help to follow the plan when necessary. CMOs are available 24 hours a day, 7 days a week to respond to families during a crisis. When a family calls after hours, the CMO is responsible for helping them implement their crisis plan and resolve their crisis.

If the CSA receives a request from a family to dispatch MRSS for a CMO involved youth, the CSA will notify the CMO of the call and if possible conference the family with the CMO. The CMO will work with the family to manage the situation by assisting the family in accessing supports and employing the crisis plan strategies. If the CSA is unable to reach a CMO, they may dispatch MRSS and MRSS will coordinate with CMO as soon as possible.

In exceptional circumstances, the CMO may coordinate with MRSS to provide a joint response to a family's crisis. MRSS will dispatch to the youth and family's home and provide intervention/de-escalation, assessment, and consultation to the CMO/CFT for planning purposes. MRSS is limited to 72 hour intervention for youth enrolled in the CMO.

iii. Interim Planning

While listening to the family's story, the CM may hear the family identify immediate needs that should be addressed before the initial CFT. CM will, with the family, make an interim plan for addressing urgent needs prior to the initial CFT with the resources currently available to the family and CM. The CM and family will identify needs and strategies to address those needs at least temporarily until the CFT can be convened. The CM will follow through with service requests and coordination of supports and services as discussed during the initial visit.

iv. Wrapping Up the Initial Visit

At the conclusion of the initial visit, the CMO will review next steps with the family. This includes engaging CFT members, convening a CFT, and gathering collateral contact information from family supports and services providers such as the youth's school, primary physician, specialty physician, psychiatrist or other mental health professional, clergy or other spiritual advisor, afterschool activity provider, friends of the youth and caregiver(s), and extended family members. Other steps will be driven based on individual family circumstances and needs. The CM, youth, and family will establish who is responsible for which tasks. The CM will review crisis plan strategies and procedures with the youth and family.

After the initial face-to-face visit with a family, CMs will seek supervision regarding information obtained in initial face to face visit per their agency policies and work towards obtaining collateral contact information and scheduling a CFT to continue the assessment and planning process to address the presenting needs of the youth.

The outcome of the initial visit is documented in the youth's Electronic Health Record (EHR) in the form of the initial Family Crisis Plan (FCP) document. This document includes fields that can be used to document needs, strategies, and service requests related to interim planning, in addition to the family crisis planning elements. See Documentation section below for documentation requirements.

v. Gathering Collateral Contacts

CM will reach out to identified collateral contacts and obtain relevant information as discussed in the initial meeting with the youth and family. Collateral information is important in accessing necessary information that will inform the assessment of needs and planning process with the family and CFT. The family may identify sources of collateral information as important members of the CFT, as their perspective may add to the breadth of the process. There is an expectation that collateral contacts will include schools, other systems (probation, DCP&P, etc.), service providers, informal supports, and medical providers at a minimum, as applicable. CMO will engage with the family to obtain necessary consent to access relevant input from collaterals. CMs are expected to maintain contact with collateral supports and providers throughout the family's involvement with the CMO to ensure that care is coordinated across systems and all parties are aware of progress and emerging needs of the family. See Documentation section below for more information on the Release of Information.

c. The Child Family Team (CFT) Process

After the initial visit with the family, the CM and family coordinate engaging potential team members and schedule a CFT. The CFT is the mechanism by which all assessment and planning for a youth and their family are accomplished. It drives all care management activities. The general goal of the CFT is to support youth and families in addressing their needs while assisting them in building strengths and a natural support system, which will allow the youth and family to coordinate supports for themselves. The CFT works toward developing a long term sustainable plan for the youth and family that can support them without reliance on a formal system to meet their needs. Through the CFT process, the team assesses youth and family needs and designs, implements, and manages youth guided and family driven supports and services for youth.

The initial CFT must be held in a timely manner so that an initial plan can be developed and approved by the CSA within 30 days from the referral date to the CMO. All family members and CFT participants, including the FSO/PSP should be invited to attend the CFT meeting in person and have a voice in the development of the youth and family's care/treatment plan. CFTs are intended to be held and are strongest when members attend in person. If there are circumstances when that is not possible, CMs can explore having members participate by other means, such as technology or through information gathered ahead of time. A family may elect to convene the CFT outside of the timeframe due to their availability or availability of key CFT members identified. In this instance, the CMO will document this per documentation guidelines. While arranging the CFT, CMs will follow-up with identified action steps from the initial visit. CMs continue to focus on relationship building with the youth and family during this time and ensure ongoing communication about ongoing activities and next steps. Engagement and building rapport are processes, and may not be accomplished with all family members by the first CFT meeting. CMs should see every interaction as an opportunity to increase engagement with caregivers, youth, and other team members, as this ensures the best opportunity for success.

CFTs are convened as driven by the need of the youth and family to assess progress, review these elements, and revise as needed. Routine CFTs are required to be held at a minimum of 90 day intervals following the initial CFT to review and update the planning process. The CFT can, and should, meet more frequently if there is a change in youth or family circumstances, an emerging or emergent need, or any situation that warrants planning revisions, including but not limited to when: a youth is psychiatrically screened, admitted to a CCIS, hospitalized, detained, or arrested. Any team member can request a CFT meeting at any time. The CM is the point person for setting up the CFT meeting. The CM will contact team members to schedule the meetings, which take place at a time and location convenient for the family members. This allows for the most flexible and relevant planning.

All outcomes of the CFT will be documented in the Individualized Service Plan (ISP), progress notes, and the Strengths and Needs Assessment. See Documentation section below for further details.

i. Composition of the CFT

A CFT has structured membership and consists of, at a minimum:

1. The youth and caregiver(s)
2. The Care Manager
3. Informal supports identified by the family, such as clergy members, family friends, or any other informal supports
4. An FSO representative, if agreed upon by the family
5. Any clinical provider involved with the youth's treatment, if desired by the family
6. Representatives from other entities involved with the youth, such as current service providers, probation/parole officers, teachers or other school personnel, if desired by the family
7. The DCP&P caseworker assigned to the youth, or their designee, if the youth is receiving protection or permanency services from DCP&P
8. Physical Health provider-pediatrician and/or specialist
9. Representatives from OOH treatment programs, if relevant

The goal for CFT membership is to have a CFT primarily composed of informal and community supports, so that the family continues to have a network of support long after transitioning out of CSOC services. While the family's initial CFT is likely to contain more formal than informal supports, the team should at all times be looking to expand the team to include informal supports as they are identified or developed. Over time, the team should expand as informal supports are identified and integrated, and should remain the same even as formal supports are phased out and informal supports continue to expand. The CFT may expand or change in membership/composition based on family request, changing circumstances, or revised treatment goals.

The CM should make every effort to assure participation of all persons requested by the family to be on the CFT. If the CM is unable to secure participation of a family-requested member despite diligent efforts, this should be documented in the progress notes and CFT meeting documentation.

ii. Roles of CFT Members

CM roles and responsibilities

The CM is responsible for convening and facilitating the CFT and process. The CM's primary role is to facilitate, implement, and monitor the informed decisions of the CFT. They are responsible for framing the CFT process and they set the tone and manage the pace of each CFT. CMs are considered the "Keeper of the Values," and as such, they ensure that the CFT embodies the Wraparound Values and Principles at all times. At the initial convening and as needed throughout the process, the CM ensures team members are introduced to one another and that CSOC approach, Wraparound, and the CFT process are fully described. The CM will review with the team the goal of the CFT, structure of the CFT, roles and responsibilities within the CFT, activities of the CFT including assessment and planning processes, in an effort to frame the CFT work going

forward. As the family builds skills through the CFT process, the family should be encouraged to coordinate and facilitate their CFT, with support and encouragement from the CM, with the ultimate goal of empowering the families to coordinate their own supports and services after transition from the CMO.

The CFT process is the continuation of the engagement process during which CM invests in relationship and rapport building with and among the members of the CFT by listening, reflecting, and being empathic. The CM should again review the Values and Principles including family friendly language, and how they drive CMO practice. The CM should ensure the CFT participants understand their roles, the importance and the necessity of their participation in the process, and that their participation is imperative for positive outcomes. The CM facilitates conversations with the team around assessment and planning processes, and is skilled at balancing views, managing dynamics and conflict, collaborating, and compromise.

Facilitating the CFT is the heart of the work of the Care Manager. CMs are charged with allowing all CFT views to be expressed and heard, including opposing viewpoints. Managing opposing viewpoints while making everyone feel heard can be challenging, and can best be accomplished by focusing on building relationships with validation and trust before building consensus. When there continues to be an impasse amongst team members despite reasonable efforts at conflict resolution, CMs should seek supervision and follow their internal practices.

CM responsibilities include, but are not limited to:

- Engaging the youth and their family in forming their unique CFT, preparing them to be full partners in the assessment, planning, and implementation of their ISP
- Convening CFT meetings, ensuring that CFT meetings are convenient for the family
- Serving as the facilitator of the CFT, ensuring that ISP development is a collaborative effort of all the Team members
- Serving as the point person for the CFT, remaining in contact with all members to ensure implementation and effectiveness of the ISP, monitoring the commitments of the team members and assisting with implementation issues
- Developing and implementing a Family Crisis Plan (FCP) in conjunction with the youth and family
- Coordinating care with all providers and agencies with whom the family is involved, including youth's physical health providers and school personnel
- Ensuring effective referrals and linkages with appropriate assessments, supports, and service
- Ensuring that all services, supports, and care management processes respect the youth and family's rights to define their specific goals and

choose their providers and resources, and monitoring to ensure that all supports and services are family friendly and culturally competent

- Communicating ongoing ISP implementation progress and updated strategies to all Team members, obtaining their cooperation and approval
- Working with other CMO staff to develop community resources to meet youth and families' needs as identified and informing the CMO of unmet needs and barriers to effective care that arise in individual planning processes
- Ensuring good information management and documentation, including attendance of team members and their approval of the ISP are documented in the youth's EHR
- Ensuring that the written ISP is signed by the youth (as age appropriate), family/caregiver(s), and the CM and placed in the youth's record within 2 weeks of the CFT meeting
- Working with the CSA to register the ISP in the EHR and initiate the authorization process for services.
- Forwarding the final approved ISP to the family within one week of the CFT, and to each team member upon request

Family and youth roles and responsibilities

- Present strengths and needs to the team as they arise
- Identify and engage potential CFT members
- Maintain communication with CM, service providers, other system partners
- Employ agreed upon planning strategies, and provide feedback to the team on their feasibility and effectiveness
- Be available for and participate in CFT meetings
- Be available for and participate in agreed upon supports and services
- Provide information required to complete NJ FamilyCare application and/or private insurance information

Family Support Organization roles and responsibilities

- Introduce their service
- Assist family in building helpful relationships
- Understand the needs of the family
- Ensure that caregivers understand the CFT process, including their role in it
- Assist family in preparation for CFT meetings, and other meetings, including but not limited to IEP and court hearings, as necessary
- Help family members identify their strengths
- Assist family in identifying potential team members
- Coach the family in techniques of self-advocacy

- Encourage caregivers to express their needs to the CM and other team members
- Support the family voice, inclusive of the youth voice
- Provide education and information
- Link caregivers to appropriate community-based supports and services
- Provide support as indicated in ISP
- Provide support during a family crisis

Other team members' roles and responsibilities

- Maintain communication with the family, the CM, and other CFT members
- Employ agreed upon planning strategies, and provide feedback to the team on their feasibility and effectiveness
- Be available for and participate in CFT meetings
- Coordinate referrals for agreed upon supports and services as indicated

When youth are involved with both CMO and DCP&P, planning is done collaboratively. DCP&P has its own Practice Model, which involves Family Team Meetings (FTM) as the basis for assessment and planning. For mutually involved youth, the CFT and the DCP&P FTM are combined into one meeting. The CM is responsible to be in contact with Case Workers routinely, and/or DCP&P administration as appropriate, and to document all outreach activities around coordination of the CFT/FTM. As sister division representatives, CM and DCP&P Case Workers will discuss in the context of the CFT/FTM the needs of the family and resources of each team member, and will coordinate which team members will be responsible for each strategy/resource depending on the needs of the family and the strengths and resources of each team member/system.

When the family hesitates to incorporate a representative from another system with which they are involved, the CM will engage the family around their concerns. They will listen and understand the concerns the family and/or youth have with having the representative participate as part of the team discussions. Once the CM understands the family's concerns, they will discuss possible solutions to those concerns, and how overcoming them in the context of the CFT with the support of the entire team can move the youth and family toward the best possible outcomes.

iii. Activities of the CFT

The CFT begins by understanding the youth and family's vision and proceeds with identifying, strengths, current needs, strategies to meet those needs, and desired outcomes. Assessment begins with the team offering the family to share their story or journey with the team.

Confidentiality

All Child Family Team members shall sign a confidentiality form at the CFT meeting agreeing to adhere to all the rules and procedures regarding confidentiality for the family and of issues discussed at the CFT meeting.

Vision

The Family Vision describes where the family wants to be in 6 months to a year. It is not a list of needs or services, but rather an expression of what the family envisions their life would be like if the current needs were met, and/or what life was like for them before their current challenges. It includes not just vision of the caregiver(s) or the vision of the youth, but the vision of the family as a whole. It provides the CFT with a focal point towards which all activities will guide the family, and provides a central theme by which all strategies are considered and measured.

The CM facilitates the discussion of the family vision within the CFT by soliciting input from each member's perspective. The CM will search for common themes and provide feedback, direct the family away from identifying needs or strategies, reframe as necessary, and negotiate differing views of team members. The goal is to create a family vision with which everyone on the team can agree, and to which everyone can commit. This may mean a very broad statement in the beginning of a family's involvement with the CMO, which may change over time as the family begins to trust the process and become more hopeful about the future.

Strengths

Strengths are things that people do well, are interested in, and come naturally to them. Strengths are identified so that they can be used to build strategies. Strengths are different than attributes. Attributes are characteristics of a person, whereas strengths refer to skills or abilities that someone has, and may include skills or abilities they had in the past and ways they managed challenges in the past. Strengths identification is an intentional process during which strengths inherent to the youth, family, and other team members are explored and identified. Strengths identified should be functional, meaning that they can be used as a basis for strategies designed to meet the family's needs.

The strengths discovery is part of the CFT process. The CM will facilitate a discussion of the strengths of each team member, guiding them toward functional strengths.

Assessment of Need

As described above, the initial work of the CFT is to understand the youth and family's perspective on their hopes for their future, and to help the family define an agreed upon vision towards which to work and measure progress. Once the family has articulated their vision, the next step of the team is to identify those things that are preventing the family from reaching their vision. This helps the team identify the needs of the youth and family. Needs are not equivalent to services; they point toward strategies that may

include a service, but may also be addressed through other methods, such as informal or community supports.

CMs use interviewing skills to help elicit additional information around presenting needs across life domains and assist the family in prioritizing these needs. The Care Manager shall ensure that information on all relevant life domains is gathered through the CFT process. NJ has identified key standard domain areas that should be considered and referenced when assessing family needs.

The planning process shall, at minimum, address areas of unmet need requiring action in all areas of the following life domains, as indicated by the SNA:

- Youth safety
- Youth risk
- Crisis management
- Emotional and/or clinical needs
- Non-clinical needs, if deemed therapeutic and approved by the CFT, such as housing, recreational, financial, medical, legal, cultural, spiritual needs
- Educational needs
- Permanency planning
- Community safety needs
- Family/Caregiver Support Needs
- Transition Needs
- Talents/Interests of the youth and caregiver(s)

Families may identify multiple needs. The CFT will assist the family with prioritizing needs based on the immediacy and severity of the needs, as well as those which reflect the family vision. Any basic needs (food, shelter, safety, etc.) identified shall receive initial priority as meeting those will allow the team to move forward to address higher level needs. Multiple tools exist (e.g., life domain cards) to assist the CM in facilitating the assessment process within the context of the CFT.

When applicable, youth safety, youth risk, permanency planning, and community safety needs shall be coordinated with DCP&P. DCP&P has the primary responsibility for youth safety under the Federal child protection mandates contained in Title IV-E of the Social Security Act. DCP&P maintains the primary responsibility for DCP&P youth in planning for well-being, permanency, and situations of abuse and neglect. Where roles overlap (well-being or treatment needs), the CMO CM and DCP&P caseworker will collaborate in the CFT on defining who will provide necessary resources for identified strategies. CMs should seek supervision when facilitating collaborative planning with DCP&P for guidance on approach and concrete strategies.

When applicable, legal and juvenile justice related needs shall be coordinated with the appropriate relevant court system partner. Where roles overlap, the CMO CM and associated system partner representative will collaborate in the CFT on defining who will provide necessary support and/or resources for identified strategies. CMs should seek supervision when facilitating collaborative planning with legal and/or court systems for guidance on approach and concrete strategies.

The Strengths and Needs Assessment (SNA) Tool

All relevant assessment information gathered in the CFT is documented on the Strength and Needs Assessment (SNA) Tool with the family to clarify the presenting needs and the strengths and needs of the youth, family, and/or primary caregiver(s). The SNA Tool is not the comprehensive assessment itself, but is used to document all needs and strengths identified through the assessment process. The SNA is the Information Management Decision Support (IMDS) Tool used by CMOs to guide treatment/care planning processes. It supports decision making about the individual treatment planning for youth and families within CMO. It supports the rapid and consistent communication of the strengths as well as the needs of youth and their families, and serves to document the identified strengths and needs of the youth and family throughout their involvement with the CMO. It can be used to track progress of the family and to ensure that the youth and family receive the appropriate services for the appropriate length of time.

The CM will introduce the family and team members to the SNA, its elements, and the process by which it is used to document the family needs and strengths. CMs will review things such as domain items, the rating scale, action levels, and connection to service planning. The CM will facilitate the discussion within the CFT to determine which items require action. All action level items will be prioritized by the family and addressed with strategies and supports in the planning process. It should be noted that assessment is an ongoing process and all needs may not be readily apparent at the beginning of the CFT process, but may emerge as relationships grow.

The SNA tool Manual and Glossary is available at <http://www.state.nj.us/dcf/about/divisions/dcsc/> and provides details on the tool design, items, anchor definitions, and more. There is also a SNA interview format tool available for CMs reference and use, and can be accessed through each CMO's IMDS Superuser.

In some situations, a youth may need an additional assessment done by someone with extra experience or qualifications, such as in substance use or developmental disabilities. The CFT will discuss accessing already existing evaluations (e.g. child study team) or pursuing further or specialty evaluations as needs present.

Planning/Strategies

Based on assessment information, the next step of the CFT is planning to address identified needs. Comprehensive treatment/care planning incorporates areas of planning for crisis situations, ongoing treatment needs, as well as transition needs. All of

these areas should be reviewed by the CFT at each meeting. It is imperative that CFTs are able to articulate why a particular plan is appropriate for the youth.

Strategies should be strengths based and reflect the steps the CFT will take to address the domains of need. These strategies should have measurable goals and time frames, identify specific individuals responsible for each strategy, and identify the roles and responsibilities of all CFT members. Strategies should be geared toward developing skills and building strengths to support long term sustainability of the plan.

Family Crisis Planning

Crisis Planning begins at the initial face to face meeting. The CM will facilitate the CFT review of the community based FCP at each meeting. As needs and resources change, the crisis plan should be updated to take into account new information relevant to the family's definition of a crisis and reflect newly developed strategies and helpful concrete strategies and community resources that can assist in a crisis. The family crisis plan should also describe a hierarchy of crisis response, based on the severity of the crisis, and who should be involved in each strategy. The FCP should direct families when to contact the CMO for their assistance in coordination of crisis strategies, and how the CMO will be available in a crisis situation, whether that will be telephonically, in person, or in some other way. The FCP should also include instructions for emergency response capability in psychiatric emergencies, including imminent risk of harm to self or others. The FCP should be built on consensus with the family as they need to feel comfortable in employing the identified strategies in a crisis situation.

Ongoing Individualized Planning

Ongoing planning by the CFT begins at the initial CFT meeting. The comprehensive assessment information gathered through the CFT process is used to drive the treatment/care planning process to address the youth and families identified needs. The planning process is individualized for each family and grounded in their strengths, and shall consist of the CFT developing outcome based, short term, interim, and long term strategies to address each area of need and life domain, according to the assessment. It is holistic in nature and addresses areas of everyday living beyond the treatment of behavioral health symptoms. The planning process shall identify all supports and services that will be used by the youth and family to implement the strategies. All supports and services should be provided in the least restrictive manner possible. The CM is responsible for being familiar with a wide breadth of local and state level resources both formal and informal, and be able to describe them to the CFT to assist them in determining the most appropriate, least restrictive, and most sustainable resource to meet a need.

The CFT treatment/care planning is a fluid, ongoing process. The plan strategies are reviewed regularly through contact with youth and family and other CFT members both at scheduled CFT meetings and in between meetings in order to ensure that the plan

and identified strategies are being implemented and assess progress being made. The development and monitoring of the plan is a collaborative effort of all the team members.

At each CFT meeting, the CM facilitates the discussion and identification of treatment/care planning elements, which include Family Vision, Strengths, Needs, Strategies, desired outcomes, and the Family Crisis Plan. These plan elements are reviewed at each meeting to determine if the strategies are effective in utilizing family members' strengths to meet their needs, thereby moving the family closer to their vision. If the CFT determines that the current treatment/care plan is not effective in helping the youth and family meet their goals, additional strategies, supports, and services will be explored.

The Care Manager is responsible for the documentation of the assessment and planning activities of the CFT in the EHR in an Individualized Service Plan document. See the Documentation section below for documentation timeframes and requirements.

CMs are required to maintain contact with the youth and family minimally weekly and to maintain face to face visits with the youth and family optimally twice per month. The number of visits will vary depending on family needs and circumstances, as discussed in the CFT and supervision. The location of face to face visits should be flexible based on the youth and family's needs and preferences. While face to face visits reflect best practice, CMs are encouraged to explore technical means of support for face to face visits, such as video conferencing, when exceptional circumstances arise. Technical supports do not supplant face to face visits, and may serve as an interim strategy to facilitate communication among CFT members and to facilitate youth and parent involvement in treatment team meetings. Use of technological means must be driven by need, discussed with the CFT, and described thoroughly in documentation. If exceptions to the face to face visit requirement occur, CMs will seek supervision and ensure that engagement attempts and justification are clearly documented in the youth's EHR.

These contacts and visits ensure that the CM gathers new information, monitors the implementation of the plan by reviewing strategies and their effectiveness, and coordinates with team members. When CMs have persistent challenges in connecting with a family, they will seek supervision to explore further options.

d. Behavioral Health Home Planning

BHH is as an addition to CMO services which provides services to youth with the goals of improving health outcomes, promoting better functional outcomes (such as increased school attendance), decreasing overall costs, decreasing costs associated with the use of acute medical and psychiatric services, improving youth and family satisfaction with care, and improving families' ability to manage chronic illnesses.

Youth who are eligible for BHH will have a BHH Core Team added to their CFT, which will build on the current CMO array of staff with the intent to provide a holistic approach to care for youth.

The CFT will be minimally expanded to include a Nurse Manager and a Health and Wellness Coach

e. Transition Planning

i. Transition from CMO

Transition planning for youth receiving CMO services is intentionally considered within the context of the ongoing ISP process, and guides the team process from the time of the family's referral. The ultimate goal of the CFT process is to empower the family to manage their own plan within the community. It is understandable that families may have needs in the future, but the goal is for them to develop skills and resources to negotiate them independent of CSOC, and rely on informal, community, and natural supports to meet their future needs and access necessary formal supports on their own. It is essential that the CM introduce this goal at the beginning of the process, and ensure that the family understands that the team will continually work with them to assess their readiness so that transition does not happen until both the family and the team feel that enough progress has been made for them to be successful with the natural and informal supports they have developed. FSO services, such as, Youth Partnerships, Warmline support, and support groups may continue after CMO involvement.

Transition planning requires the CM to balance the family's current need for support with preparing them to transition out of CSOC by teaching the family the process of the CFT. From the initial meeting forward, the CM will encourage the family to drive the CFT process by reinforcing their strengths, highlighting their successes, and empowering them to apply the skills learned to problem solve on their own.

A transition plan is formally developed if one or more of the following criteria are met:

- The goals of the ISP have been substantially achieved
- The CFT determines that the youth no longer requires the intensive level of care management provided by the CMO
- The CFT determines that the youth is ready to be transitioned to adult services
- The family requests transition, or is unreachable for an extended period of time, despite documented best efforts to contact family
- The family or youth moves out of New Jersey
- The youth is sentenced to a term of incarceration

ii. Transitioning to Adulthood

Before a youth reaches the age of 18, the CFT should be considering what supports and services he or she may need as he/she approaches adulthood. If a young adult needs further supports after the age of 18, the team should be coordinating linkages to adult systems and planning with the young adult for his/her transition to those services. This may include, but is not limited to, planning for and developing supports to address

mental health needs, medical needs, developmental needs, housing needs, career and/or employment needs, and educational needs.

The age of transition out of CSOC and into adult services should depend on the needs of the youth, and which systems can best meet those needs between the ages of 18 and 21. While a young adult is eligible for some adult services upon his/her 18th birthday and eligible for DDD services upon his/her 21st birthday, in exceptional circumstances, CMOs can continue to remain involved during the year in which a young adult is 21 if the team needs that time to develop a strong transition plan to support long term sustainability.

The Protocol for Transition Planning document contains information regarding transition plans, identifying what the young adult's needs are, what is already in place, and what needs to be put in place to make the transition to the adult system as smooth as possible. This document is filled out during CFT meetings as part of the Transition Planning process.

The Protocol for Transition Planning document is available at <http://www.state.nj.us/dcf/adolescent/YouthResourceGuide.pdf>.

A copy of the Transition Planning Tool is available at <http://nj.gov/dcf/providers/csc>.

The Office of Adolescent Services has highlighted principles that can help CMs support youth in successful transitions to adulthood. These principles are available at <http://www.nj.gov/dcf/about/divisions/oas/OASSuppReport120611.pdf>.

iii. DD Eligible Transition Age Youth

DD eligible youth who are transitioning out of children's services and continue to need supports upon their transition out of CMO, require CMO coordination with the Division of Developmental Disabilities (DDD). In order to receive supports and services from DDD at the time at which they turn 21, young adults must be determined DD eligible by DDD (see Section 4 for more information on DD eligibility), must maintain NJ FamilyCare eligibility, must complete a NJ Comprehensive Assessment Tool (NJ CAT) to help determine what supports are available to them. Young adults must also apply for Supplemental Security Income (SSI), which is a program that provides benefits to adults who have disabilities and have limited income and resources, and assures NJ FamilyCare eligibility.

Educational entitlement past the age of 21 is not a barrier to transitioning to DDD.

DDD provides a resource to assist young adults in transitioning into adult life titled Planning for Adult Life. This resource is available at www.planningforadulthood.org.

For young adults who are transitioning into community based support, CMs, in the context of the CFT, will coordinate with the DDD Supports Program. The Supports Program funds services and supports for adults with intellectual and developmental disabilities who live in non-licensed settings. Transition planning for DD eligible young

adults should start as early as possible to ensure a smooth transition to adult DD services, minimally 6 months prior to a young adult's 21st birthday. More information about the Supports Program is available at: <http://www.nj.gov/humanservices/ddd/services/>

Upon enrollment to the Supports Program, families will select a Supports Coordination Agency, who will assist them in initiating the person centered planning process.

For young adults whose needs may require an OOH treatment setting at the time of transition please see Section 7: Out of Home Treatment for information on the DD Roundtable Process.

iv. Guardianship for I/DD Youth

In situations where transition age young adults need assistance with treatment planning, decision-making, and other life skills, it is important for CFTs to discuss these needs and include them in the transition planning process.

Support in decision-making skills can be obtained through multiple strategies and with multiple parties supporting different life domains. In some situations, youth and families may decide a young adult needs support in a majority of life decisions, and may choose to pursue legal guardianship.

There are several options for pursuing guardianship:

- If there are family members or family friends available to serve as guardian, those individuals can pursue guardianship without involving the DHS Bureau of Guardianship (BGS) by hiring a private attorney or by filing a guardianship petition pro se using the forms available on the judiciary website. There are also agencies that will assist families who wish to pursue guardianship pro se. Filing for guardianship outside of the BGS process is usually the fastest way of obtaining guardianship.
- Family members or family friends may also pursue guardianship through the DHS BGS. The BGS process also involves the Superior Court; however, BGS manages the entire process. If an individual qualifies for a priority referral to BGS, the process may take about a year. If an individual does not qualify for a priority referral to BGS, the BGS option can take several years to be completed due to the number of families in the BGS queue. The young adult must have been determined to be eligible for DD services through DHS DDD. More information on the BGS process, including FAQs and a resource link can be found at <http://www.state.nj.us/humanservices/ddd/services/guardianship/>
- If a youth is involved with DCP&P and there are no family members or family friends who can serve as guardian, the DCP&P caseworker will be primarily responsible for pursuing guardianship through BGS. The young adult must have been determined to be eligible for DD services through

DHS DDD. CMOs are expected to collaborate with DCP&P for mutually involved youth.

f. Documentation and Recordkeeping

CMOs shall maintain all information required by CSOC or their designee on youth and families for services rendered to a youth receiving CMO services. Required documentation is designed to thoroughly and accurately reflect the process and content of the CFT assessment and planning processes. All information discussed within the CFT process should be reflected in fact based statements and in a timely fashion. Treatment plan, assessment and progress note types are available within the youth's EHR and have parameters guiding the content and purpose of each document. Specific treatment plan and progress note types are required in certain situations. All CFT assessment and planning processes will be documented in the EHR.

CMOs are responsible for maintaining clinical, fiscal, and other records as required by regulations, statutes, accrediting organizations, governmental agencies, or other administrative entities. At a minimum, CMOs would be expected to maintain records in accordance with N.J.A.C.10:49-9.8. If a CMO is engaged with multiple agencies that require varying timeframes for recordkeeping, the CMO would be expected to maintain records in accordance with the lengthiest requirement. CMOs must be able to furnish any requested documentation upon request.

The CM is expected to keep the youth's EHR current. The CSA website houses webinars on how to enter documentation into the EHR, including the Face Sheet, Diagnosis, Provider Tab, Demographics Tab, Informal Supports Tab, etc.

CMOs must maintain the following information in support of all CMO activities:

- The name of the youth
- The name, agency (if applicable), and the title of the individual providing the service
- The dates of service
- The length of time that the service was provided
- The length of time of the face-to-face contact (excluding travel to or from youth contact)
- The name of individual(s) with whom contact was maintained on behalf of the youth

i. ISP Documentation

The ISP is the documentation of the work of the CFT. The initial ISP must be completed, approved by the supervisor, and submitted to the CSA within 30 days of the youth's referral to the CMO, and include service authorization requests for any services deemed necessary by the CFT. Services can be authorized for a maximum of 90 days from the date of the CFT.

The planning process and subsequent ISP document is more than a collection of services. It integrates services with family strengths and natural support systems to

achieve common goals. The ISP document should record the ongoing work of the CFT and all elements of the planning process and agreed upon implementation plan. Each ISP document should include information in the following areas:

- The participation of providers and local community partners, and the integration of available and appropriate services and resources
- Documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable
- The specific supports and/or strategies identified and/or implemented to support the youth, including planning for the purchase of items or services necessary to support the youth/family's needs as determined by the CFT
- The involvement of the Family Support Organization (FSO), if desired by the family
- If applicable, a plan for permanency, clinical care, and youth and community safety (DCP&P maintains the primary responsibility for permanency and youth safety for DCP&P youth)
- Measurable goals and the criteria to be met to obtain those goals
- A plan for transitioning the youth from CMO services to a community based, natural support network of services and supports
- The signatures of the CMO Care Manager, the caregiver(s), and the youth receiving services
- Documentation of the coordination of applicable services with the physical health insurer
- A community based crisis management plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond Care Manager response

After the planning process, CM will obtain supervision as indicated in agency policy around the CFT meeting, assessment, and planning processes and development.

The team can expect that the ISP document will be written, provided to the family within one week of the CFT, and provided to each team member upon request. All changes to the ISP are agreed upon by the CFT and, at a minimum, signed by youth, caregiver(s), and Care Manager. The ISP is entered into the youth's EHR and submitted to the CSA within 7 days of the CFT meeting. CMs will also review the Meeting Attendance Sheet at every CFT. The Meeting Attendance Sheet is to be signed by all CFT members, and indicates attendance at the CFT, agreement with the ISP, and that a choice of providers was offered to the family. This document will be uploaded into the youth's EHR prior to the submission of the ISP. The Care Manager makes a copy of the updated ISP available to each team member following each meeting.

The ISP is required to be updated and approved by the CSA at a minimum every 90 days; more often as new information, behaviors, or needs become apparent. The ISP is updated in conjunction with the CFT.

A list of trainings on how to navigate and document within the youth's EHR is available at <https://apps.performcarenj.org/NJTraining/courselist.aspx>. This site houses additional information on management tools within the EHR, such as welcome page functionality, which is helpful to CMs.

Certain documentation requirements, i.e., releases of information, wrap/flex documentation, external evaluations, DCP&P documents, correspondence, CFT attendance records, court documents, will be maintained outside of the EHR according to individual agency policy.

ii. Release of Information

When seeking collateral information and/or documentation, CMs will obtain a signed Release of Information from the family prior to contacting any collaterals. As part of this process, CM will review the purpose and the scope of the information being obtained.

Certain bodies of information, such as substance use treatment, have different requirements for releasing information. CMs should consult with their supervisors to ensure the parameters for appropriate release of information are met.

iii. Plans CMOs Develop:

The following grid outlines the plan types available in the EHR for CMOs to use, and their parameters. Existing relevant assessments, such as the SNA, should be reviewed concurrently and considered in within the plan review process.

Plan type	Purpose	Elements	Due by	Updated when	Svc/auth limit
Family Crisis Plan	Documents the Family Vision and what to do in the event of a crisis	Family Vision, Definition of a crisis, strengths/interests to use in a crisis, what helps in a crisis, Resources to be used in a crisis, medical problems, add'l information	Initial FSP due 7 days from youth's referral, then with every CFT (including emergency CFTs)	Whenever there is a crisis to amend as necessary, and at each CFT meeting	Only with first FCP if an emergent need exists, up to 30 day auth period
Initial ISP 30 Days	Document the results of the first CFT	Family Crisis Plan, Family Vision, Strengths, Needs, Strategies, Diagnosis, Service Request(s), Supports, Attendance	30 days from youth's referral to CMO	At the next CFT meeting	Up to 90 day auth period
Comprehensive Review 90 Day	Document the results of each CFT	Date of meeting, Crisis Plan, Family Vision, Strengths, Needs, Strategies, Diagnosis, Service Request(s), Supports, Attendance	Within 90 days of the Initial ISP or last Comprehensive Review 90 Day	Whenever a CFT meeting is held	Up to 90 day auth period
Service Change	Document a change to an existing service or correct error	Copies all elements of the plan	When needed	When a new service provider needs to be put in place	Services only entered until 90 days after the last plan
Service Update	Document significant changes to ISP, incl. FSP, as driven by CFT	Copies all elements of the plan except Service Request	When needed	When there is a change to the ISP that does not involve changing/adding a service	There are no services requested on this plan
Transition ISP	Documents all of the work toward family transitioning out of CMO svcs., incl. when transferring to another CMO	Copies all elements of the plan except Service Request; adds Discharge Section	When family is ready to transition out of CMO services	When a youth has successfully completed CM services, the family has decided to transition, or family unreachable for a time	There are no service requests on this plan
BHH Transition	Document when a family transitions out of BHH services but remains open with CMO				

iv. Plans CMOs Review:

The CFT determines all necessary supports and services for a youth. For any authorized services, service providers are responsible for documenting the youth/family's treatment plans in the EHR, and the CM, as the facilitator of the CFT, is responsible to ensure they have been reviewed by the CFT. When youth is in an OOH treatment setting, the CM is responsible to enter a progress note into the youth's EHR indicating the CFT's agreement with the plan submitted by the OOH treatment provider. Existing relevant assessments, such as the SNA, should be reviewed concurrently and considered in within the plan review process.

Plans CMs should expect to review in a CFT include:

- Out of Home Treatment Provider Plans
 - Joint Care Review - JCR
 - Transitional JCR - TJCR
 - Discharge JCR – DJCR
- IIH Behavioral BCBA or Clinical Provider Plans
 - Functional Behavioral Assessment – FBA
 - Behavior Support Plan – BSP
 - Intensive In Home Plan – IIH
- IIC Provider Plans
 - Intensive In Community Plans
 - Behavioral Assistance Individual Service Plans – BA ISP
- ISS Provider Plans
 - Individual Support Service Plan – ISS – Revised CABS

v. Progress Note Documentation

CMOs must enter progress notes into the EHR for each contact or collateral activity rendered on behalf of a youth or family/caregiver. Progress notes must contain, at a minimum:

- The date, location (as appropriate), and time(s) of each service
- The length of face-to-face contact, excluding travel time to or from the location of contact with the youth/family, or the length of time and type for each collateral contact
- The names, titles, organizations, and phone numbers of relevant collateral contact(s)
- A summary of the service activity

More details on Progress Note Types, including time frames, can be found in the EHR Documentation Guide.

vi. Substance Use Documentation

Substance use information should be documented in the youth's EHR as it is relevant to the needs of the youth and family, and the planning process. CMs are able to document coordination of care relative to substance use needs, and should follow standard HIPAA regulations regarding confidentiality, as they are not considered substance use treatment providers.

vii. BHH Documentation

Documentation requirements for BHH services include:

- Initial Nursing Assessment
 - Due within 30 days of opening the BHH tracking element
- Nursing Assessment Updates
 - Required annually, can be updated as needed
- Quarterly Progress Note
 - Due within 30 days of opening the BHH tracking element, and required every 90 days thereafter
- BHH Transition Plan
 - Required any time a youth transitions out of BHH services but stays open with CMO
- Nursing and Wellness Coach input is incorporated into the CFT SNA process.

g. CMO Annual Review and Documentation Process

CMOs are required to conduct an annual review process for all youth engaged with CMOs. Primarily, the Annual Review allows the Child Family Team (CFT) to review the youth & family vision, strengths & needs, and progress towards identified goals over the course of both the most recent 90 days as well as over the past year. In addition, the Annual Review allows the CFT to highlight any recommended changes in therapeutic services and to re-assess whether requested services (e.g., IIC or wrap/flex funded services) continue to be appropriate to address the youth and family needs. The review also allows the CSA to review youth care plans in order to assess whether or not the youth continues to meet CSOC Clinical Criteria for identified and requested services and supports. The outcome of this review process is documented in the youth's EHR.

Section 6: Supports and Services Available

I. Introduction

As part of the process toward long term, sustainable planning the CFT is responsible for identifying supports and services that will most suitably allow the identified strategies to be implemented to meet the immediate needs of the youth and family, while preparing them to support the CFT process in the long term without formal CSOC provider involvement. The CMO CM is expected to be well versed in available statewide and local services and resources, and to be able to describe these within the CFT context relevant to the particular youth and family. The CM facilitates linkage to and communication with identified supports and services around service initiation, support strategies, coordination of progress monitoring, CFT meetings, planning changes, and newly identified needs.

The CMO CFT membership is impacted by the identified supports and services as those identified persons become members of the CFT and planning process. Intentional identification of natural and informal supports by whom youth and family are frequently supported by nature of family or community dynamics and relationships is integral to helping the family create a sustainable support network. These resources may take time to identify and often families will have a higher amount of formal supports initially, while informal and natural supports are being identified and developed. The goal of the CFT over time is to move towards a ratio of support for youth and families that is higher in informal and natural supports than in formal providers and supports so that the family has a support network that can be maintained long after their transition out of CSOC.

Each CMO is required to partner with its local community to develop a network of providers with the capacity to meet the needs of the youth and families served by the CMO on a system level as well as on an individual youth level.

The process for building a provider network on a system level is as follows:

1. Identify all available services and community resources in the CMO service area available to support strategies identified in the ISP.
2. Determine the need for additional capacity and/or new services and supports. CMOs are responsible for assuring that the youth and their family is offered a choice of at least two entities that can provide the needed service.
3. Build upon existing resources available within the CMO designated service area.
4. Partner with CSOC to support the creation of additional services and supports when a full network is not available. All CMOs have access to Community Resource Development (CRD) funds annually to develop resources within their respective communities to fill services and support gaps to meet the needs of the youth and families they serve.
5. Develop Memoranda of Understanding (MOU) with all service providers within the CMO network to support the provision of the services identified in the ISP. MOUs will be

reviewed by the CMO routinely to ensure that they are consistent with expected practice and CSOC policies.

6. Manage and monitor the network of service providers. CMOs will convene routine provider forums to develop and maintain relationships with local providers, review expectations for coordination of service delivery, and discuss quality of service provision.

For individual youth, the CFT will work as outlined in Section 5 to identify supports and services to meet the identified needs of the youth and family. When necessary supports and services are not available, the CM will use its internal process for notifying CMO administration of a service gap in order to explore all available options to meet the present need for a family, and to incorporate the community service need into a local planning discussion. Local CMO administration will coordinate with their CIACC around identifying and filling service gaps, and engage DCF in planning when necessary. See Section 8 for more information on how to coordinate with local CIACCs.

CMs should be familiar with the following services and how to access each. They should be able to describe the service and discuss the process in the context of the CFT.

II. Wrap/Flex Funds

To support the CFT efforts toward using creative, unique strategies to meet the family's needs, CMOs have access to Wrap/Flex funding as a last resort for supports and services not covered by NJ FamilyCare, private health insurance, or any other funding source. This funding can be used for a spectrum of interventions ranging from specialty evaluations to cleats for the youth to join a sports team to basic needs. Supports and services provided through Wrap/Flex funding must be directly related to meeting an identified goal on the family's ISP. The CFT should develop a plan to ensure the sustainability of supports provided through Wrap/Flex funds. See the CSOC policy on Flex Funding in Appendix G of this manual and follow your agency's protocol for accessing these funds.

III. Community Resources

Community resources are integral to making ISPs individualized, community based, flexible, sustainable, strengths based, and cost effective. Community resources can include informal supports, and formal community supports that families can access at little to no cost. These supports are key to creating a long-term, sustainable plan for the family, and include resources such as community centers, neighbors, faith based organizations, libraries, and many more. CMOs maintain ResourceNets, which are databases of available local community resources and information.

The more development and engagement of these resources happens on the system level, the more options will be available for CFT planning from which the family may choose, to meet their individual needs and support their strengths and values.

IV. Intensive In-Community Services (IIC)

IIC Services are flexible, multi-purpose, in-home/community based supports for caregivers and youth with behavioral and emotional needs who are receiving CMO or MRSS services. Regulations governing IIC services are located at N.J.A.C. 10:77 Subchapters 4 and 5. These services are designed to be delivered by a licensed, independent practitioner, or delivered under the supervision of a licensed, independent practitioner. The purpose of these interventions is to strengthen families, build family stability, and preserve the family in the community. These services are flexible both as to where and when they are provided, based on the family's needs and preferences. They are implemented based on targeted needs as identified by the CFT, and should include specific interventions with target dates for accomplishment of goals that focus on the restorative functioning of the youth. Clinical criteria for these services are available at <http://www.performcare.nj.org/provider/clinical-criteria.aspx>.

These services may also facilitate a youth's transition from an intensive treatment setting back to his/her community. They are designed to be time limited with the objective of helping the youth and family transition to community based mental health services which are congruent with their treatment needs. Interventions are delivered with the goal of diminishing the intensity of treatment over time.

IIC Services include several modalities of intervention, including IIC Clinical services, Behavioral Assistance (BA), and Social Emotional Learning (SEL).

Youth receiving IIC will have a comprehensive treatment plan, individually tailored to address identified behaviors that impact on the youth's ability to function at home, in school, or in the community, which incorporates generally accepted professional interventions. The treatment plan must be authorized by the CSA.

For youth receiving CMO services, this plan is part of the youth's ISP, as developed by the CFT. The CFT is responsible for identifying the need for IIC services, and CMs ensure families are offered a choice of providers. CMs submit an IIC service request for the provider chosen by the family, and coordinate directly with the provider. A standard referral form for referring families to IIC services is in development. Care Managers are responsible for monitoring the youth and family's progress within the IIC services. They do this by keeping in routine contact with the family and the provider, asking targeted questions around progress toward engagement with the family, level of family participation, implementation of strategies, progress toward goals, barriers to implementation, new needs identified, and other relevant questions as applicable. The goal is to ensure that the family's needs are being met and that the information is shared with the rest of the CFT. IIC providers are expected to be active participants in the CFT process, preferably in person, but through technological means at minimum. IIC providers can participate through conference calls, email communication, and telephone calls. IIC providers are expected to document their efforts in the youth's EHR. CMs should be communicating with their supervisors to report youth and family progress toward goals, and to discuss any questions, concerns, or challenges that arise around IIC treatment provision so that CMOs can track individual youth and family progress as well as system level successes and challenges.

Youth receiving IIC services may also be eligible additional supports, including Behavioral Assistance (BA) and Social Emotional Learning (SEL). In addition to the youth's IIC Comprehensive Treatment Plan, youth receiving these supports will have additional targeted service plans which will outline the strategies to address the identified behaviors. CMs manage these services as described for IIC above.

BA Services are specific, outcome-oriented interventions that are components of an approved, written, detailed plan of care prepared by a licensed clinical behavioral healthcare practitioner, most often the IIC provider who is working with the family. BA is a dynamic process of intervention and ongoing evaluation resulting in effective modification of a youth's identified behavior. BA Services involve applying positive behavioral principles within the community using culturally based norms to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life, and strengthen skills in a variety of life domains. BA Services are face-to-face interventions provided individually with the youth and his/her family/caregiver(s) that will provide the necessary support to the youth to attain the goals of the service plan.

The goal of SEL services is to provide a foundation of skills that can be applied to all aspects of the youth's life. The expected outcomes for these services are to improve a youth's emotional stability. SEL is a skill building approach that uses concrete prompts and cues to build and strengthen life skills as well as build core competencies for navigating life and its challenges, specifically in the areas of self-management, self-awareness, decision making, social awareness, and interpersonal interactions. To be eligible for these services, a youth must have a behavioral health diagnosis, be enrolled in the CMO, and meet the continued stay criteria for CMO. These services are provided by a Behavioral Assistant certified in SEL, on the recommendation of the IIC or other clinician already working with the family.

V. MultiSystemic Therapy (MST)/Functional Family Therapy (FFT)

MultiSystemic Therapy (MST) is an intensive family and community based treatment that addresses multiple aspects of serious antisocial behavior in adolescents. MST typically targets chronic, aggressive juvenile offenders who are at high risk of OOH treatment away from their families. The MST approach views the youth's behavior as being influenced by the surrounding "systems" – family, peer, school, and neighborhood – as well as by the youth's thoughts and feelings about those systems.

Family Functional Therapy (FFT) is a family-focused, community based treatment for youth who are either "at risk" for, or who manifest antisocial behavioral challenges such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting out and substance use disorders. Co-morbid behavioral or emotional challenges such as anxiety or depression may also exist as well as family communication challenges and conflict. FFT has been applied to a wide range of families with at-risk, preadolescent, and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in juvenile court, in community based clinic or outpatient settings, and at times of transition from institutional treatment settings.

These two services can be accessed directly from community providers or system partners. The programs coordinate with the CSA regarding service requests and authorizations. For youth enrolled in the CMO, if the CFT determines that the youth is in need of one of these services, the CFT must create a transition plan that includes MST/FFT, and coordinate with the service provider so that there is continuity of care during the transition.

VI. Outpatient

Outpatient services are behavioral health interventions that are rendered under the supervision of a licensed behavioral healthcare practitioner (Psy.D., Ph.D., Ed.D., M.D., LCSW, LPC, LMFT, APN) in an office, clinic, youth's home, or other community locations. Services may include, but are not limited to, individual, family, or group psychotherapy/counseling. Services focus on the alleviation of symptoms that interfere with functioning in at least one area of the youth's life (e.g. familial, social, education) as well as the restoration, enhancement, and/or maintenance of a youth's level of functioning.

Families can access outpatient services directly from community providers. Families may also access them by calling the CSA directly for a list of local providers, or by calling their private health insurance carrier for a list of outpatient providers in their healthcare network. Outpatient services for youth receiving CMO will be coordinated through the CFT process. The CFT will factor the family's insurance coverage, specialty needs, and family's choice of provider into the planning process. Outpatient service requests will be included on the family's ISP as part of the comprehensive plan of care, although authorizations by the CSA are not currently required for service provision.

Outpatient providers are expected to participate in the CFT process, at minimum through conference calls, email communication, or telephone calls at regular intervals to coordinate planning and treatment for mutually involved youth across settings and monitor progress. CMs are expected to engage outpatient providers in the CFT process and maintain regular contact with them to coordinate treatment planning and discuss youth and family progress.

VII. Partial Care (PC) including Intensive Outpatient (IOP)

Partial Care is an intensive, nonresidential, therapeutic treatment program that may or may not be hospital-based. The program provides clinical treatment services in a stable environment. These services are outcome oriented for children and youth experiencing acute symptoms or de-compensating clinical conditions that impede their ability to function on a day-to-day basis, and who may be at risk of inpatient care without daily programming. Partial Care programs provide seriously emotionally disturbed youth with a highly structured intensive day treatment program. Treatment may include individual counseling or group counseling and support; therapeutic activities to address daily living (ADL) skills, recreation and stabilization needs; medication management; family support services such as family therapy, family psycho-education, supportive counseling, or parenting skills development; psychiatric assessment; case coordination; liaison with the educational system, referral, advocacy and service linkages; and therapeutic milieu activities, such as community meetings, behavior management programs, and related programming. The partial care will provide referral, case coordination, and advocacy

for all services needed by the youth that are not directly provided by the partial care. These service needs and their appropriate provision will be documented in the youth's ISP. Services may vary from 2 to 5 days per week for up to 5 hours a day and should be coordinated with the child/youth's educational programming to ensure the continuation of the youth's education, as stipulated by New Jersey State Law. Low intensity partial care services are often referred to as Intensive Outpatient (IOP).

Families can access PC services directly from community providers. Families may also access them by calling the CSA directly for a list of local providers, or by calling their private health insurance carrier for a list of PC providers in their healthcare network. PC services for youth receiving CMO will be coordinated through the CFT process. The CFT will factor in the family's insurance coverage, specialty needs, and family's choice of provider into the planning process. PC service requests will be included on the family's ISP as part of the comprehensive plan of care, although currently authorizations by the CSA are not required for service provision.

PC providers are expected to participate in the CFT process, at minimum through conference calls, email communication, or telephone calls at regular intervals, to coordinate planning and treatment for mutually involved youth across settings and monitor progress. CMs are expected to engage PC providers in the CFT process and maintain regular contact with them to coordinate treatment planning and discuss youth and family progress.

VIII. Partial Hospitalization

Partial hospitalization is an intensive, nonresidential, therapeutic treatment program that may or may not be hospital-based. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on less than a 24-hour basis. These services are outcome oriented for children and youth experiencing acute symptoms or decompensating clinical conditions that impede their ability to function on a day-to-day basis, and who may be at risk of inpatient care without daily programming. Treatment may include therapeutic milieu; nursing, psychiatric evaluation, medication management /education, group/individual/family therapy, supervised clinically appropriate leisure time and/or vocational programming. Partial Hospitalization services are used as a time limited response to stabilize acute symptoms. Partial Hospitalization services may be utilized as a step-down from inpatient services or out of home treatment services or to stabilize a deteriorating condition and avert hospitalization. Treatment efforts need to focus on the individual's response during program treatment hours, as well as the continuity and transfer of treatment gains during the individual's non-program hours in the home/community. Services may vary from 2 to 6 days per week for up to 6 hours a day and should be coordinated with the child/youth's educational programming. Provision is made for the continuation of the child/youth's education as stipulated by New Jersey State Law.

Families can access PH services directly from community providers. Families may also access them by calling the CSA directly for a list of local providers, or by calling their private health insurance carrier for a list of PH providers in their healthcare network. PH services for youth receiving CMO will be coordinated through the CFT process. The CFT will factor in the family's insurance coverage, specialty needs, and family's choice of provider into the planning process.

PH service requests will be included on the family's ISP as part of the comprehensive plan of care.

PH providers are expected to participate in the CFT process, at minimum through conference calls, email communication, or telephone calls at regular intervals, to coordinate planning and treatment for mutually involved youth across settings and monitor progress. CMs are expected to engage PH providers in the CFT process and maintain regular contact with them to coordinate treatment planning and discuss youth and family progress.

IX. Boggs Center Technical Assistance

CSOC has arranged for the Boggs Center to offer Technical Assistance (TA) to the CMO for youth who are identified as having intellectual and/or developmental challenges or a dual diagnosis of I/DD and mental health challenges with extremely complex needs. Youth enrolled with the CMO who present with the most challenging behavioral needs should be considered for referral. Youth do not need to have been deemed DD eligible for referral for TA.

A CFT may face challenges in assessment and community based planning for youth and families with complex needs, and can benefit from expert TA within the team composition. Boggs TA will provide CMOs with support within the Wraparound model for youth and families by having expertise available to CFTs around assessment and planning issues with which the team needs direction.

X. Supports and Services requiring Developmental Disability (DD) Eligibility

a. Family Support Services (FSS)

Family Support Services are intended to help support families for individuals who are DD Eligible and living in their own homes. Under the direction of the New Jersey Council on Developmental Disabilities, Regional Family Support Planning Councils assist CSOC by making recommendations based on input they receive from families.

CSOC evaluates requests for FSS based on a youth's and family's need, the services and supports already available and/or being used, and the availability of CSOC resources. FSS is not an entitlement and cannot be guaranteed. Budget allocations dictate the availability of services. Families must exhaust any other services to which they are entitled before they can receive assistance through Family Support.

Applications for FSS are completed by the family calling the CSA. CMOs should support this process when necessary, based on family need. These services are not requested through the ISP process, however the EHR should indicate when a family has a need for these services and the progress toward accessing them. The CFT is responsible for assisting the family with the application process and advocating with the family.

Further information and fact sheets are available at <http://www.performcarenj.org/families/disability/index.aspx>.

The following FSS services are generally offered throughout New Jersey:

i. Respite

Respite provides caregivers with a short period of rest or relief by arranging alternate caregiving for the youth with a developmental disability. Respite also can be provided when the family caregiver is temporarily absent or disabled for any reason, such as for a short period of hospitalization. Respite usually is provided by a CSOC approved agency that is qualified to provide this service.

Respite includes:

- After school activities
- Weekend recreational activities
- Short term care in a licensed setting
- In-home respite by a respite agency provider staff
- Self-directed respite by an individual the family identifies

ii. Camp

CSOC provides families of eligible youth with financial support towards summer camp tuition. Financial support is based on available resources in a given fiscal year. The amount of financial support available per individual is capped and may vary from year-to-year, depending upon how many families apply.

Before requesting funding for camp, a family should always ask the Department of Education for an extended school year for their youth.

Applications are accepted between March and April of each year, and are completed by the family and submitted by them directly to the CSA. Dates are posted each year on the CSA website. CMs should be familiar with the application process and be able to discuss it in the CFT. CMs should support the family in completing the application. Applications for Summer Camp can be found on the CSA's main website at <http://www.performcarenj.org/index.aspx>.

iii. Assistive Technology Devices

Assistive Technology Devices are used to increase, maintain, or improve a youth's functional capabilities. They include materials and services meant to improve the quality of life by:

- Making the environment more accessible
- Allowing the youth to compete in the workplace (excluding items covered by vocational rehabilitation services)
- Enhancing independence

Unless an Assistive Technology Device is available from only one vendor, families seeking them must obtain three competitive bids.

iv. Home and Vehicle Modifications

These are removable, structural modifications such as ramps, grab bars, etc., although an exception may be granted in cases where a modification affects a youth's mobility, such as a roll-in shower or a garage conversion.

Updated information is provided at <http://performcarenj.org/families/disability/index.aspx>

b. Intensive In-Home Services (IIH)

IIH Services are an array of rehabilitation and/or habilitation services delivered face-to-face as a defined set of interventions by clinically licensed or certified practitioners to youth with intellectual and/or developmental disabilities. IIH Services are geared to augment those services already being provided in the school and other settings; they do not supplant existing services. All other benefits for which the youth may be eligible, such as educational entitlements, SSI, and private insurance, must be accessed before accessing IIH resources. Services are not guaranteed, and are based on the youth and family's need, and availability of resources.

IIH Services are provided in the youth's home and/or in community based settings, and not in provider offices or office settings. Providers must be able to safely address complex needs and challenging behaviors, including, but not limited to noncompliance with verbal or written directions, tantrums, elopement, property destruction, physical or verbal aggression, self-injurious behaviors, and inappropriate sexual behavior.

These services are provided as part of an approved intensive, individualized in-home service plan and encompass a variety of clinical and behavioral interventions, supports, and services, including, but not limited to Clinical (Rehabilitation) Services, Behavioral (Habilitation) Services, and Individual Support Services (ISS).

Families must be enrolled in the CMO to access IIH Behavioral Services, and either the CMO or MRSS to access IIH Clinical and/or ISS Services. For CMOs, these services are coordinated through the CFT process, requested through the ISP, and require CSA authorization. These services are generally offered independent of each other, however if a family is assessed to need more than one of these services, CMs should seek supervision to discuss the family's needs and coordinate the most appropriate array of supports and services.

IIH providers are expected to participate in the CFT process, at minimum through conference calls, email communication, or telephone calls at regular intervals, to coordinate planning and treatment for mutually involved youth across settings and monitor progress. IIH providers are expected to document their efforts in the youth's EHR. CMs are expected to engage IIH providers in the CFT process and maintain regular contact with them to coordinate treatment planning and discuss youth and family progress.

i. IIH - Clinical Services

These services are delivered as necessary to improve the youth's independence and inclusion in his/her community. These services are flexible, multi-purpose, in-home/community, clinical supports for youth and their parents/caregiver(s). Rehabilitation services are short term medical or remedial services designed for the restoration of a youth under the age of 21 to his or her best possible functional level after an acute episode of physical or mental disability or a long term mental illness.

IIH - Clinical supports and services include, but are not limited to:

- CSOC IMDS SNA or other CSOC approved or required IMDS Tool
- Other assessment tools as indicated (clinicians must be familiar with the array of considerations that would indicate preferred assessment methods)
- Individual, family, and/or group counseling
- Positive Behavior Support
- Instruction in adaptive frustration tolerance and expression, which may include anger management
- Instruction in stress reduction techniques
- Problem solving skill development
- Psychoeducational services to improve decision making skills to manage behavior and reduce risk behaviors
- Social skills development
- Trauma informed counseling
- Implementation of an Individualized Behavior Support Plan, if present
- Coordination with agency staff and participation in the clinical team
- Collaborating effectively with professionals from other disciplines that are also supporting the youth, including, but not limited to educational providers, clinicians, physicians.
- Recommendations for referrals for medical, dental, neurological, or other identified evaluations

ii. IIH Behavioral Services

These services include a comprehensive, integrated program that supports improved behavioral, social, educational, and vocational functioning. In general, this program will provide youth with services such as developing or building on skills that would enhance self-fulfillment, education, and potential employability. Habilitation services are long term supports designed to assist youth with I/DD in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to function successfully in home, at school, and in community based settings.

IIH Behavioral supports and services include, but are not limited to:

1. Applied Behavior Analysis (ABA) Functional Behavior Assessment (FBA) and related assessments, e.g., preference assessments, reinforce assessments, etc.
2. Behavior Support Plan
3. Level of Functioning in the six major life areas, also known as Activities of Daily Living (ADLs) as measured by the Vineland or other similar accepted tool
4. Appropriate augmentative and alternative communication supports and functional communication training, e.g. visual schedules, contingency maps, Picture Exchange Communication System (PECS), wait signal training
5. Instruction in ADLs
6. Implementation of an individualized Behavior Support Plan
7. Individual behavioral supports such as Positive Behavior Supports
8. Training/coaching for the youth to meet individual behavioral needs
9. Support and training of the caregiver(s) to successfully implement the Behavior Support Plan, use Assistive Technology, and other support services as needed, gradually diminishing the need for outside intervention
10. Modifying Behavior Support Plans based on frequent, systematic evaluation of direct observational data
11. Training and supervising support staff to provide in home ABA services
12. Recommendations for referrals for medical, dental, neurological, or other identified evaluations
13. Coordination of support with agency staff and participating as part of the clinical team
14. Collaborating effectively with professionals from other disciplines who are also supporting the youth, including, but not limited to educational providers, clinicians, physicians
15. The Functional Behavior Assessment and development of a Behavior Support Plan shall be an integral part of the treatment planning process for those identified youth

For more information, see the IIH Clinical Criteria at <http://www.performcare.nj.org/provider/clinical-criteria.aspx>.

iii. IIH Individual Support Services (ISS)

ISS assist youth with acquiring, retaining, improving, and generalizing the behavioral, self-help, socialization, and adaptive skills necessary to function successfully in the home and community. Individual Support workers provide services directly to the youth through evidence-based and data driven methodologies. These services address adaptive behavior and skill development for activities of daily living; basic or instrumental. Supports may be supervised by service provider staff in a participant's family home, the home of a relative, or in other community based settings, in accordance with approved treatment plans. Staff who provide ISS must meet the minimum levels of education, experience, and training as described in the DHS/DCF Contract Manual, IIH Clinical Criteria, or as required for NJ FamilyCare participation.

Supports in the youth's home cannot exceed 10 hours per week. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. Services are prior authorized by the State or its designee, based on a needs assessment and as delineated in the treatment plan.

IIH ISS supports and services include, but are not limited to:

Basic ADLs (for all ages; consist of self-care tasks)

- Bathing and showering
- Dressing
- Eating
- Personal hygiene and grooming (including washing hair and brushing teeth)
- Toilet hygiene

Instrumental ADLs (age 16 and up; skills are not necessary for fundamental functioning, but enable an individual to live independently)

- Housework
- Taking medications as prescribed
- Managing money
- Shopping for groceries or clothing
- Use of telephone or other form of communication
- Using technology (as applicable)
- Transportation within the community

For more information, see the ISS Clinical Criteria at <http://www.performcare.nj.org/provider/clinical-criteria.aspx>.

Please see Appendix C for Practice Guidelines for Care Management Organizations Serving Youth with Intellectual and/or Developmental Disabilities and Serious Behavioral Challenges

c. DD MCO Care Manager

Youth with DD eligibility and NJ FamilyCare eligibility are considered a special population and have enhanced benefit package through the designated MCO, and assigned a care manager. MCO care managers assist families with coordination of benefits and service referrals for necessary supports via phone. CMO CMs can assist the family in requesting an assessment for this service if it is not already in place. Once the service is in place, MCO's care managers can serve as a resource to the CFT.

XI. Substance Use Resources

CSOC coordinates services for youth whose functioning is impacted by substance use. Currently, the substance use services offered by CSOC are limited to youth ages 13 up until their 18th birthday who meet clinical criteria for substance use treatment (SUT). Youth who are

18 years old may also qualify for CSOC substance use treatment services if they are actively in high school or actively pursuing their education, and/or would be best served in an adolescent program. Please refer to the Provider FAQ's which are posted on the CSA website for additional information related to SU Treatment Resources: <http://www.performcarenj.org/provider/substance/index.aspx>.

Youth can be referred for substance use assessment and treatment services by DCP&P, Juvenile Court, designated county substance use coordinators, MRSS, CMO, schools, or one of the contracted substance use treatment provider agencies. Families and youth may also contact the CSA directly to access an assessment for services.

If the CSA determines a youth has indicated needs for further substance use assessment, the CSA will either refer the youth to a substance use treatment provider for a substance use assessment using American Society Addiction Medicine (ASAM) Criteria, or refer the youth for a specialty substance use BPS/Needs assessment done by a substance use provider or IIC provider who is dually licensed. A BPS/Needs, whether provided by a substance use provider or an IIC provider, must be authorized by the CSA. The SUT Provider List, which can be found on the CSA website, will identify approved substance use providers.

A youth or family may present directly to a substance use provider for assessment and/or services, in which case the provider will reach out to the CSA for authorization and IOS determination.

If the youth is already enrolled in the CMO and the CFT determines that he or she needs a substance use assessment, the CFT has the same options available as outlined above for substance use assessment. Once a youth has been assessed, the assessor provides recommendations for substance use treatment to the CSA. The CSA reviews the assessment, completes a Level of Care Index (LOCI) tool, and authorizes the appropriate level of care.

Substance use treatment levels of care include detoxification, co-occurring residential out of home treatment programs, partial care, intensive outpatient, and outpatient. Co-occurring programs operate from a treatment model to ensure that needs from all relevant life domains, including behavioral health, are integrated into the treatment planning process.

Youth authorized to receive co-occurring out of home treatment will be enrolled with the CMO at the time of authorization. The out of home treatment provider will discuss the CMO service with the youth and family and obtain appropriate information disclosure consent that protects substance use diagnosis and treatment information as prescribed by the Code of Federal Regulations (CFR) confidentiality rule (42 CFR Part 2) for treatment from the youth and family. The substance use treatment provider will contact the local CMO with which the youth has been enrolled to coordinate service delivery on the day of enrollment. The CMO will coordinate with the youth and family to begin the CFT process. Engagement around substance use treatment needs is most successful when team members explore and understand the youth and family's motivational level for treatment. Although youth and families are required to be enrolled in the CMO and participate in the CFT process to remain in a substance use treatment program, CMs should work to engage with youth and families in substance use treatment in the same way they

would with families from other referral sources, understanding that they may be in a different stage of change readiness than families who have come to the CMO voluntarily.

Section 7: Out of Home Treatment

I. Introduction

A core value of the Wraparound approach is that youth have more sustainable success when they can remain in their homes and their communities, with supports and services that meet their needs in their natural environments, where family and community connections can be maintained and strengthened. The goal of the CMO is to provide necessary supports and services in the community whenever possible. Some youth experience needs during the course of their treatment that may prompt the CFT to consider a higher intensity of service than can be provided in the youth's community, such as Out of Home (OOH) treatment.

Out of Home treatment is a time limited intervention aimed at stabilizing a youth's identified behaviors and needs and addressing the underlying etiology of these behaviors and needs so that he/she may safely return home or to a non-clinical setting (such as a resource home) with as little disruption to his/her life as possible. The goal of OOH treatment is to facilitate the youth's reintegration into his/her family and community or into an alternative permanency plan preparing for independent living.

OOH treatment is the CSOC's highest level of intervention and thus should only be accessed when all other therapeutic interventions have been considered and OOH treatment is determined by the CFT, based on the youth's assessed clinical treatment needs, to be the most appropriate level of intensity of service, given the needs of the youth. CSOC strives to reduce OOH lengths of stay to an average of 9 months, and successfully provide OOH treatment in one episode per youth. CSOC provides a continuum of OOH Treatment Intensities of Service (IOS).

OOH treatment settings are distinct from DCP&P identified "placement" settings, which are designated for youth who are unable to remain in their own homes due to issues of abuse, neglect, and/or permanency. DCP&P placements offer different levels of supervision and structure, and focus on supporting youth in achieving permanency.

Youth with more acute behavioral health needs have access to additional intensities of service through other NJ State Departments. These higher IOS programs include CCIS Units for youth at imminent risk of harm to self or others, and Intermediate Units for youth who need continued treatment in a hospital setting following transition from a CCIS Unit. CSOC does not coordinate admission to these units, however CMs must be familiar with these resources and are expected to collaborate with them to plan for CMO enrolled youth in need of these services. Transition out of CCIS and Intermediate Units for mutually served youth should be coordinated through the CFT process as with any other OOH IOS. CSOC has defined a process for CCIS programs to refer youth directly to the PCH OOH IOS, although the CMO is still responsible to complete the OOH Referral Process referenced in this Section. See Section 8: Coordination and Collaboration with System Partners and Other Entities for more information on CCIS Units and Intermediate Units, and how CMOs interact with them.

For youth involved with the Juvenile Justice system, a judge may order CMO to assess the youth's needs to determine if the youth meets the criteria for and can benefit from OOH treatment, as IOS determinations are made based on the clinical needs of the youth. The court should not order specific IOSs. When a court orders an assessment, the CFT is required to obtain the appropriate clinical evaluations regardless of parental and/or youth consent or CFT agreement. The CFT should follow the same assessment and decision making process they follow for youth who are not under a court order, and should be planning concurrently for a community based plan. See Section 8: Coordination and Collaboration with System Partners and Other Entities for more information on following court orders.

II. Intensities of Service

CSOC serves youth with a wide range of challenges associated with emotional and behavioral health, intellectual/developmental disabilities, and substance use. CSOC is committed to providing a full continuum of OOH services based on the individualized need of each child and family within a family centered, strengths based, culturally competent, and community based environment, at the intensity, frequency, and duration needed.

Clinical criteria for each OOH IOS are available online at: <http://www.performcarenj.org/provider/clinical-criteria.aspx>.

The full continuum of OOH services includes the following, from highest to lowest intensity:

a. Behavioral Health:

1. Intensive Residential Treatment Services (IRTS) (by CCIS request only)
2. Psychiatric Community Home (PCH)
3. Specialty (SPEC)
4. Residential Treatment Center (RTC)
5. Residential Treatment Center Co-Occurring, Mental Health and Developmental Disability (RTC-MH/DD)
6. Co-Occurring, Substance Use (RTC-SU)
7. Group Home (GH)
8. Treatment Home, including Co-Occurring (MH/DD-TH)

b. Intellectual/Developmental Disabilities (IDD)

1. Intensive Psychiatric Community Home – IDD (IPCH-IDD)
2. Intensive IDD - (I-IDD)
3. Psychiatric Community Home – IDD (PCH-IDD)
4. Specialty – IDD (SPEC-IDD)
5. Group Home Level 2 – IDD (GH2-IDD)
6. Group Home Level 1 – IDD (GH1-IDD)
7. Special Skills Home, Level 1/Level2 – IDD (SSH-IDD)

c. Stabilization Services

In addition to the OOH Treatment options listed above, CSOC has access to OOH stabilization services for youth with urgent needs. These services include Crisis Stabilization and Assessment Centers, Urgent Respite, Emergency Diagnostic Reception Units, and Treatment Home Stabilization Services.

i. Crisis Stabilization and Assessment Centers (Crisis Stabilization Bed)

A crisis stabilization bed is a short term emergency group home model specifically designed for DD eligible youth in immediate need of out of home stabilization and assessment services, whether due to their behaviors or the caregiver(s)' inability to care for them due to medical/legal emergencies or abuse/neglect. These programs are intended to engage and stabilize the youth, obtain appropriate evaluations, initiate developmentally appropriate services, implement skill building activities, and reunify the youth with his/her family. These resources are regionally based and designed to serve specific age groups. The CM is responsible for working with the family toward the youth's return home, while continuing to plan for the youth based on the youth's assessed needs. This may include planning for the youth to return to the community, for the youth to go to an OOH treatment setting, or a concurrent plan including both. Crisis Stabilization is the equivalent of EDRU programs described below, but specifically designed for I/DD youth.

CMs can make referrals for Crisis Stabilization Beds once all community resources have been exhausted. Referrals are made by contacting the CSA. DD eligibility is required, however if the youth has not been previously determined DD eligible but meet other admission criteria, the CM will work with the CSA and the CSOC gatekeeper to begin the eligibility process and to allow the youth access to the service while the DD eligibility process is completed. Contribution to Care (C2C) does not apply to Crisis Stabilization Beds. For more information on C2C, see OOH Referral Request Process below.

ii. Urgent Respite Access

CSOC has limited access to urgent housing for DD eligible youth whose family circumstances require the youth to stay in an alternate location for short periods of time. If a youth has a developmental disability but has not previously been determined DD Eligible, and the youth is in urgent need of OOH Respite, the CM will, whenever possible, assist the family in submitting all DD Eligibility required documentation to the CSA and requesting an expedited eligibility review by contacting the CSA Service Desk. When all necessary documentation is not available to complete an expedited eligibility review, the CM will follow the DD Presumptive Eligibility Process, which requires the family, with support from the CM, to submit all available documentation to the CSA. The CSA will coordinate with CSOC regarding DD PE as necessary. OOH Respite programs support eligible youth with appropriate staff supervision and minimal behavioral support services as needed. Access to education is also provided. Urgent Respite can be accessed in urgent situations by CMOs. Parents may also access these programs in

certain situations. All requests to access this service are made through the CSA or CSOC designee. CMs are required to provide documentation relevant to the youth's functioning, including a Child Adaptive Behavior Summary (CH ABS) form, IEP, medical documents, or other applicable assessment. These services are time limited until the youth's family situation is resolved or until the youth can be admitted to a longer term appropriate setting.

iii. Emergency Diagnostic Reception Unit (EDRU)

The EDRU will accept, on an emergency same-day basis, youth in crisis who are experiencing emotional/behavioral challenges, in the home, school, or community, and who require an OOH treatment setting, and are not at imminent risk of harm to self or others. These youth are at high risk of homelessness due to their emotional/behavioral challenges and family circumstances, and would benefit from time limited services to stabilize, assess, and develop an appropriate treatment plan. When a youth is involved with DCP&P, the DCP&P representative will complete the referral and provide necessary documentation. If a youth is involved with CMO only and the CFT determines he/she is in need of this level of service, the CM should seek supervision to review the youth's needs and ensure that all community resources have been exhausted before making a referral. The CMO administration is responsible for contacting CSOC to make the referral and follow through with the referral process.

The EDRU Better Access to a Safe Environment (BASE) Program is a type of EDRU program specifically designed for youth involved with human trafficking.

iv. Treatment Home Stabilization Services

Treatment Home Stabilization Services support Treatment Home agencies in the management of escalating behaviors to help a youth stabilize and maintain their treatment setting. The scope of stabilization services available to youth in a treatment home IOS includes access to IIC, BA, and, for youth residing in an IDD Skill Home – Level 1, IIC Clinical Services. When the need for this service arises, the treatment home provider will collaborate with the CFT prior to requesting the services to ensure that all team members are aware of the request. This includes discussing who will request the service, either in a JCR or an ISP. Typically, this service is requested by the treatment home provider, but there are some circumstances under which the CMO can request the service.

For further details, see the Treatment Home Stabilization Services Provider Communication and Process at: <http://www.nj.gov/dcf/providers/csc/>.

d. Substance Use Co-Occurring Treatment Programs

Substance use co-occurring OOH programs are not accessed through the YouthLink process described below. Youth may be admitted to these programs if a substance use evaluation indicates a need for an OOH IOS. Access to a substance use evaluation is described in Section 6. If a youth has a substance use evaluation that has been completed within the last 30 days,

the CM will send the evaluation (if not available in the EHR) along with a completed Referral Request Form for Substance Use and a Consent for Release of Confidential Information about Alcohol or Drug Information and Other Protected Health Information (PHI) to the CSA via fax. These forms and the fax number are located at <http://www.performcarenj.org/provider/substance/forms.aspx>. Upon receipt, the CSA will review the information and make an IOS determination based on ASAM clinical criteria. Often, youth are at the OOH treatment program where the assessment occurred when the IOS determination is made. Youth may be immediately admitted to that program or transferred to a more appropriate treatment setting. If the youth is not immediately admitted to the program that completed the evaluation or is in the community when the IOS determination is made, CMs will discuss treatment provider options, and coordinate admission with the family and the provider as necessary.

The CM will coordinate with the family as outlined below in Coordinating Care for Youth in OOH Treatment. This includes ensuring that the CFT closely collaborates with the substance use co-occurring OOH provider on monitoring progress and transition planning. Due to privacy laws, CMs cannot view documentation from the OOH treatment program in the EHR.

See Appendix F: Working with Youth with Co-Occurring Behavioral Health and Substance Use Needs

III. OOH Referral Request Process

Prior to submission of an OOH Referral Request, CMO must facilitate a CFT meeting to discuss the current needs of the youth based on existing assessment information, develop a plan for the youth to return home as soon as possible, and obtain supervisory consultation and approval. The CFT must conclude and communicate that the youth will benefit from OOH treatment, that the youth meets the clinical criteria for OOH treatment, why community treatments options are inadequate to meet the youth's needs, what the family's responsibilities will be during the time the youth is in OOH, and obtain consent from the youth and family for OOH treatment. The family must be willing to attend CFT meetings, participate in therapeutic services, and interact with the youth regularly both in the program and at home. Removing a youth from his/her home for treatment has a significant impact on a youth and his/her family, and must be done thoughtfully to maximize the treatment benefit potential, reduce the youth's length of stay, maintain family relationships, and increase the sustainability of the youth's progress.

Once the CFT determines the above, the CM follows the Out of Home Referral Request process as outlined below. This may involve securing additional information and/or assessments.

For youth who are DD eligible, Contribution to Care (C2C) discussion and documentation must be part of the referral process. According to NJ statute, DD eligible youth/young adults or parents of a DD eligible youth under 18 are required to contribute toward the cost of care for out of home services provided based on their ability to pay, when the OOH provider is not reimbursable under NJ FamilyCare. It is important for families to understand the requirements of C2C so that they can make informed decisions about their youth's care when considering OOH treatment options. When OOH treatment is discussed by the CFT for a youth who is DD

eligible, the CMO will discuss this requirement with the caregivers/responsible party and provide them with the C2C Fact Sheet. CM will collect the necessary information to complete the Pre-admission Form, and forward that on to the DCF C2C Unit. The DCF C2C Unit will then send the family the Financial Packet, and the CM will follow up with the family/responsible party to ensure that the forms are completed and the necessary information is provided to the DCF C2C Unit, as the youth/young adult cannot be admitted to an OOH treatment program until C2C requirements are met. Once the family/responsible party has completed the C2C requirements and the youth/young adult is admitted to the OOH treatment program, the CM completes the Post-admission Form and submits it to the C2C Unit. Please note: it is very important that this form is completed any time a DD eligible youth enters an OOH treatment program where C2C applies, transfers from one OOH program to another where C2C applies, or transitions out of OOH treatment. Annual reassessment is also required. C2C for youth under the age of 18 for whom DCP&P has custody and guardianship is handled according to DCP&P's process, and CMs should ensure that C2C requirements are discussed in the CFT.

Care Managers must complete an OOH Referral Request and upload required supporting documentation in the youth's EHR in order to have the OOH referral reviewed by the CSA for intensity of service determination. The Document Upload Requirement Checklist – Out of Home Referral Requests outlines the requirements for OOH Referral Requests, and can be found at <http://www.performcarenj.org/pdf/provider/ooH-referral-request.pdf> . CMs must also complete a CFT Update Progress Note, which outlines why OOH treatment is needed for the youth at this time. The CSA determination for an OOH Intensity of Service (IOS) is based on the clinical information provided in the CFT Update Note, the OOH Referral Request, as well as in required supporting documentation. Therefore, it is imperative for the success of the OOH referral process that all information be current, clear, and accurately documented.

Once the CSA has reviewed a complete OOH Referral Request and determined an intensity of service, the youth's name will be posted on Youth Link, and made available to providers whose profiles match the youth's identified intensity of service needs and clinical specifiers to review. YouthLink is an electronic file created and maintained by the CSA to manage referrals for out of home treatment statewide.

The OOH Referral Request is used only for the youth's initial entry into OOH Treatment. There are additional processes described below for youth who are ready to transition into a lower OOH IOS or into the community.

When DCP&P has custody or guardianship of a youth and CMO is not involved, they may initiate a referral for CSOC OOH services by completing a telephonic review process through the CSA. The youth will be enrolled with a CMO at this time and planning for the youth's needs will be driven by the CFT/FTM process.

The Out of Home Referral Request Manual outlines how to complete the OOH Referral Request document, and is available online at <http://www.performcarenj.org/pdf/provider/out-of-home-referral-request.pdf> .

A copy of the Policy #4 for Admissions to Out of Home Treatment Settings is available online at: <http://www.state.nj.us/dcf/providers/csc/index.html> .

Once the CSA reviews the OOH Referral Request and makes an IOS determination, providers are able to review the youth's information via YouthLink and reach out to the CMO if they feel their agency's treatment setting and milieu would benefit the youth and meet his/her specific needs. CMs are expected to review YouthLink routinely, reach out to the providers who have been matched to the youth, and ensure that the process moves forward by advocating for the youth with providers and addressing barriers. Once a youth is assigned to a provider, the CM will send the referral packet to assigned providers to ensure that the provider has access to the necessary information to move the referral forward. Sometimes, the CFT decides not to pursue a particular recommended program(s). In these circumstances, the CMO should send a courtesy email to the provider(s) cordially declining consideration of the assigned provider as a treatment facility. This allows the provider to review referrals for other youth awaiting treatment.

CMs schedule and are required to attend Meet & Greets with providers and families, where youth and caregivers are introduced to treatment options, have an opportunity to ask questions, and have their concerns addressed so that youth and families can make an informed treatment decision. CMs are responsible to support families in the Meet & Greet process to ensure that families have ample opportunity to ask questions of the provider. CMs will ensure follow up visits and/or phone calls are made, as families should have multiple opportunities to meet with treatment providers so that they have adequate information to make a decision, and to have all of their concerns addressed. These meetings are integral to beginning the engagement process between OOH providers and families and set the foundation for family involvement throughout the youth's stay in the OOH treatment setting. CMs will also assist families with gathering required documentation, including but not limited to medical information, birth certificates, educational records.

Imperative to the OOH treatment planning process is planning for the continuation of the youth's education. CMs must coordinate with the youth's school district and the youth's parents to obtain necessary documentation that will enable the youth to be registered with and attend the appropriate school environment while in an OOH treatment setting. Proper paperwork and the support of the CFT enables OOH treatment providers to register youth in the local school district or other appropriate educational setting. Under certain circumstances, the youth's school district is unable to be determined or unwilling to assume responsibility. In such situations, the CMO must complete the DOE District of Residence Determination Form. See the Interagency Guidance Manual at <http://www.nj.gov/dcf/families/educational/stability/> for more information on helping youth in OOH treatment succeed in school.

In the context of the CFT, the OOH treatment options are discussed and team assists the youth and family in choosing which provider will best meet the youth's needs. Once a provider is selected, the CM will coordinate with the provider and the family to schedule an admission and gather all required documentation

CMs have access to a consultation process with the CSA for youth who have been on YouthLink for 30+ days and for whom no prospects for acceptance into any OOH treatment

programs exist. This is referred to as a Tier II Consultation Process. Instructions, tips and forms for Tier II Consultation are available <http://www.performcarenj.org/provider/forms.aspx> . For youth who remain on YouthLink 45+ days, CMs must complete a progress note indicating the youth's continued need for OOH treatment, indicating whether or not the youth's needs have changed since his/her IOS determination was made. If the youth no longer requires OOH treatment, the YouthLink referral should be cancelled and the progress note should state the reason for cancellation. If updated clinical information has been obtained, an updated OOH Referral must be completed. If barriers to accessing OOH treatment exist, the CM should seek supervision with their CMO administration to discuss the strategies employed to overcome those barriers, as well as to identify alternatives to OOH treatment that have been considered and/or attempted.

a. Access to the Specialized Residential Treatment Unit (SRTU)

CSOC has a Specialized Residential Treatment Unit (SRTU) which provides consultation on OOH process and to facilitate coordination of referrals to OOH treatment and provide consultation on OOH access and utilization for specific IOSs, including PCH, SPEC, IPCH-IDD, PCH-IDD, I-IDD, RTC-MHDD, SPEC-IDD, as well as specialized OOH programs for pregnant/parenting youth, youth with specialized medical needs, and youth involved in human trafficking. The programs at these IOS levels are only accessed through SRTU **AFTER** the CSA makes an IOS determination. There are also time limited programs accessed through a designated CSOC SRTU representative outside the YouthLink process. These programs include Detention Alternative Programs (DAP), Better Access for a Safer Environment (BASE) (a short term program for youth potentially involved with human trafficking), and Emergency Diagnostic Reception Unit (EDRU). The EDRU is accessed only when emergency admission is needed. CMs are also able to access SRTU support for specialty populations during the CFT's consideration of OOH treatment options for youth with medical needs, with intellectual and developmental challenges, and/or who are pregnant/parenting. See Access to the Specialized Residential Treatment Unit at: <http://www.nj.gov/dcf/providers/csc/> for information on when and how to contact SRTU.

If the Intensity of Service (IOS) meets criteria for SRTU consultation as outlined above, the CSA will instruct the Care Manager to send an e-mail with an attached SRTU Cover Letter - <http://www.performcarenj.org/pdf/provider/srtu-cover-letter.pdf> to the following e-mail address: SRTUconsultation@dcf.state.nj.us. Within 3 days of receipt of the SRTU Cover Letter, the SRTU Consultant will match appropriate programs to the youth based on his/her clinical needs and manually post the youth's name on identified providers' queues on Youth Link. CMs should proactively review YouthLink to further facilitate the referral process. The Accessing DCF Children's System of Care Out of Home Treatment document includes further information about all steps of the OOH referral process, including requirements for sending information to identified programs. CMs should be aware of the CSOC "no eject/no reject" policy for the PCH and SPEC level IOSs. This policy requires PCH and SPEC level programs to accept all youth referred unless there are concerns the program cannot meet the youth's clinical needs. In this instance, program representatives must seek and obtain approval from SRTU to not accept a youth.

b. IOS Dispute Process

In some instances, the CFT may agree that a different IOS may be most beneficial in meeting the youth's needs. If additional information has been obtained that would describe a youth's needs more accurately and support a different IOS determination, the CM should submit the additional information in a new out of home referral request to the CSA for review and IOS determination or email the CSA Service Desk indicating that additional information has been added to the EHR and the CFT is requesting a review of the IOS determination.

In some instances, a CFT may have awareness of a different IOS out of home treatment resource they feel could meet the youth's needs most beneficially due to individualized circumstances (close to family, small setting, etc.), or the CFT may disagree with the CSA's IOS decision in general. In these circumstances, the CM should seek supervision and the CM supervisor may fill out the IOS dispute form found at <http://www.performcarenj.org/pdf/provider/intensity-service-dispute-form.pdf> and follow the IOS dispute process as outlined in <http://www.performcarenj.org/pdf/provider/intensity-service-dispute-process.pdf>. Family involvement in this process is required.

IV. Coordinating Care for Youth in OOH Treatment

OOH treatment begins on admission, with the goal of returning the youth to his/her home. CM coordination of the CFT process, as outlined in Section 5: CMO Program Model remains the same when a youth enters an OOH treatment setting, and the OOH provider joins the CFT to collaborate on assessment and planning. The location of CFT meetings must be flexible to allow for maximum attendance and participation, and may take place outside of the OOH treatment program. While youth is in an OOH treatment setting, the OOH treatment program is responsible for documenting the SNA in the youth's EHR and for documenting the youth's treatment plan into a Joint Care Review (JCR) rather than an ISP. The treatment team at the OOH program is responsible for implementing treatment strategies related to the youth's clinical needs, and CMs, who must attend OOH treatment team meetings, are responsible to ensure integration of the OOH treatment team and the CFT. For youth involved with DCP&P, CMs must ensure that the youth's DCP&P representative is fully integrated into the treatment team and the CFT. For youth under probation supervision, CMs ensure that OOH treatment providers have a copy of the youth's most recent court order, so that the CFT can address court ordered stipulations. CMs are responsible for ongoing coordination of care for youth in OOH treatment to ensure the youth is making progress toward the youth and family's identified goals and that the youth and family are preparing for the youth's return home with necessary supports. CFTs must intentionally plan for the youth's transition home from the beginning of OOH treatment. CMs must ensure that routine, structured contact between the treatment provider, the family, and themselves is occurring to discuss the youth's progress. The CM is also responsible to ensure that planning strategies include the family's involvement with the youth, both in the program and the youth's home, as clinically appropriate. Youth who receive treatment away from their home face physical separation from their home and their family. Maintaining strong connections to their home and their community is integral to achieving the best outcomes at the time of their transition home. CMs are expected to be the lead in

coordinating treatment goals with the CFT, which includes the OOH provider, and that goals are being adjusted, based on ongoing assessments of the need. CMs need to ensure the responsibilities laid out for each party are being carried out and any barriers to them being implemented are addressed. When new needs arise, or if progress is not meaningful, the CFT will adjust treatment goals and interventions. Minimally, CFTs are held every 90 days, the results of which are documented in a Joint Care Review (JCR) by the OOH treatment provider in the youth's EHR. CFT agreement with the JCR is documented by the CM in a progress note in the youth's EHR upon submission of every JCR.

CMs are responsible for face-to-face visits for youth in out of home treatment, optimally twice a month or more frequently as the youth's needs for support by a CM indicate. Most typically, face-to-face visits with youth should include the CM visiting the youth in their out of home treatment setting. Face to face visits which don't include visiting the youth in their out of home treatment setting can occur as a youth's needs indicate. CMs must also maintain visits with the family as indicated by their need, as this is essential to the youth's care, the family's involvement in the youth's care, and the youth's successful return home. Planning for therapeutic home visits/routine times for youth to go home is a key component of treatment and offers the opportunity for youth and family to function in their relationships supported by skills learned and strategies to address needs. Discussion of therapeutic home visits support early and routine transition planning. The CFT is responsible for assisting the family with arranging therapeutic leaves including planning around transportation. Family involvement in the youth's treatment setting, including therapeutic services and engagement with youth daily activities is key towards the ultimate goal of reintegrating the youth to the community and home successfully.

For youth who are under probation supervision, CMs should ensure that probation is notified of scheduled therapeutic leaves. Probation conducts home visits prior to a youth's initial therapeutic leave, provides support to the family, and may conduct unscheduled visits to the home while the youth is on leave.

Ideally, CMs will bring CFT members to consensus on a plan to address the youth's behavioral health needs. Proactive coordination of treatment plan elements typically helps everyone focus on the same outcomes. When the team members are unable to reach consensus, the CM will ensure that team members feel that each of their concerns are fully understood. FSO support can be valuable when family members do not feel that their concerns are being addressed. CMs will also revisit the Family Vision with the team to refocus team members on the long term goals of the youth and family. If the team is unable to reach consensus after voicing their concerns and revisiting the Family Vision, CMs will engage CMO administration for supervision and support to overcome barriers. Team members, including CMs, family members, or representatives of other systems, may have different perspectives on the most immediate needs of the youth and family. Engaging CMO administration may offer information to team members that can move them closer to consensus. Additionally, CMO administration system level collaboration and relationship building can provide avenues to address challenges in navigating differing system or provider perspectives. Communication among provider and system

administrators gives the opportunity to share more information relevant to CSOC practice and policy, and to both prevent and overcome barriers to consensus.

CMO representatives routinely review youth in OOH treatment settings. Youth with lengths of stay over 9 months receive a more in depth, comprehensive review.

Youth who are enrolled in substance use co-occurring OOH treatment are required to remain open with the CMO for the duration of the SU OOH treatment. Every attempt should be made by CMO and SU treatment providers to engage families with youth in SU OOH treatment who want to disengage from CMO services. CMO and SU providers must collaborate on best engagement strategies to understand the family's position and underscore the benefits of CMO involvement during the youth's substance use treatment. Families are required to have CFT with the CMO and SU provider, who are jointly responsible to collaborate with the family to develop a comprehensive transition plan prior to transitioning from CMO services. The discussion should include continued service needs, and how services will be supported as well as funded once the family is no longer enrolled in the CMO.

V. Transition from OOH Treatment

The CFT should be considering the youth's transition back to his/her home at the time of referral to OOH treatment, and the transition should be considered throughout the youth's stay. Before a youth transitions out of OOH treatment into the community, the CFT must have developed a plan to support the youth and his/her family. The plan must be specific, and should include appropriate clinical interventions, informal supports for the youth and caregivers, a newly developed crisis plan based on the youth's current needs, and any necessary educational supports. Whenever indicated, specific contact information and appointment dates for formal services should be included. The OOH treatment provider will submit the final JCR, which must include all transition plan elements, supports and services, identified, progress towards goals, etc.

Ideally, the youth receives time-limited treatment in one OOH treatment program then returns home. Sometimes a youth's needs require the youth to transition from one OOH treatment setting to another, either because another program is better suited to his or her needs, the youth's treatment episode was interrupted, or the youth becomes eligible for adult mental health or DD services and supports. See below for the processes to transition youth in these instances.

a. Transition to Alternate OOH Treatment Settings

In a situation in which a youth's needs are not being met in an out of home treatment setting and the CFT continues to recommend out of home treatment, the OOH provider is responsible for submitting a Transitional Joint Care Review (TJCR) in the EHR, which is completed in collaboration with the CFT. This TJCR will include information on interventions provided, progress toward goals, continuing needs and clear recommendations for ongoing interventions. As part of this process, the CM must upload any updated evaluations through the document upload process and complete a CFT note documenting the youth's continued need of OOH

treatment. Please go to <http://www.performcarenj.org/provider/behavioral/forms.aspx> for the Document Upload Requirement Checklist for the TJCR. The CSA determines the youth's intensity of service and the youth is placed on Youth Link. The CM follows the processes outlined above to pursue admission to a different out of home treatment program. During the process, the youth remains at the current treatment setting pending identification of and transition to the new treatment setting.

b. Transition Due to Special Circumstances

Sometimes, a youth may leave an OOH treatment program prior to the completion of his or her treatment goals and outside of the ISP, either because the youth is missing or due to emergent circumstances. While OOH treatment programs (per NJ FamilyCare regulations) are required to hold a youth's bed for at least 5 days (when youth go missing) or 14 days (for example, when youth are admitted to a hospital or detention), OOH treatment programs are allowed some discretion in determining how long to hold a youth's bed beyond those parameters. If the OOH program submits a Discharge JCR due to the youth no longer being present at the program, and the CFT determines that the youth is still in need of OOH treatment, then the CM is required to complete a new OOH Referral Request and, in the context of the CFT, plan for any interim needs while the youth awaits OOH treatment.

c. Transition to DDD OOH Supports

For I/DD youth approaching age 21 who are in need of DDD OOH supports at the time they transition out of CSOC, CMs must coordinate with DDD through the established DDD/DCF Roundtable process. CMs are expected to take the lead throughout the transition of a youth to DDD. The initial roundtable is ideally held when a youth turns 18 so that DDD may proceed with completing the Developmental Disability Resource Tool/NJ Comprehensive Assessment Tool (DDRT/NJCAT) to determine the IOS needs and budget. Currently, youth who are involved with CMO and DCP&P are referred to the round table process at age 18, while discussion for youth involved with CMO only begin the round table process at age 19 1/2. This may include youth who are currently in an OOH setting, as well as youth who require an OOH setting upon transition who may currently be receiving community supports. CMOs must complete the DDD/DCF Roundtable Request Form to initiate this process. Prior to initiating the process, youth must have a DD eligibility determination, and have applied for SSI and NJ FamilyCare. Please see Section 4: Access and Eligibility for more information on DD Eligibility. Youth should apply for SSI when they turn 18. Youth who are receiving SSI prior to their 18th birthday will need to reapply upon their 18th birthday. When DCP&P is involved with the youth, CMO must coordinate with DCP&P to obtain necessary information to complete the Roundtable Request Form. CMO will submit the Roundtable Request Form to the CSOC designee, who will coordinate with CMO, DDD, and DCP&P (when necessary) to schedule a Roundtable meeting. CMs must participate in the Roundtable process, and should attend the Roundtable meetings when possible. If barriers such as geographic distance arise, CMs may consider technological means of participation, such as conference calls or video conferencing. Roundtable meetings will be scheduled at regular intervals, typically monthly, until the CFT and Roundtable teams

develop a concrete transition plan including time frames that meets the needs of the youth, or until the youth transitions into the appropriate setting.

CMOs must remain involved when transition planning continues past a youth's 21st birthday, as long as a youth remains in a CSOC funded OOH treatment program.

d. Transition to DMHAS OOH Supports

For youth over 18 with mental health needs who are in need of OOH supports upon transitioning out of CSOC OOH treatment, CMs must coordinate with local DMHAS providers to plan for a young adult's OOH supports. CMs should seek supervision when they need support navigating the adult behavioral health system.

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Section 8: Coordination and Collaboration with System Partners and Other Entities

Every CMO has a routine mechanism to coordinate and problem solve with all their local partners. Individual or more specific issues are resolved within the CFT process.

I. Children's Inter-Agency Coordinating Council (CIACC)

CIACCs serve in an advisory capacity to both county government and DCF. They participate in:

- CSOC quality assurance processes
 - Cross-system planning at the local level
 - Regional or inter-county coordination activities
 - Conducting, facilitating, and/or identifying training and technical assistance needs
- CIACCs, to the extent possible, are to represent all the various service systems, community based organizations, natural family supports, religious entities, as well as racial/ethnic populations.

Local CIACCs are comprised of representative from each of the following five categories:

- Youth and family representatives (voting members)
- Local system partners (voting members)
- Community based organizations (voting members)
- County planning entities (voting members)
- Representative of State agencies (ex-officio, non-voting members)

In collaboration with DCF, local CIACCs strive to ensure a seamless array of services. The CIACC serves as the county mechanism to advise DCF on the development and maintenance of a responsive, accessible, and integrated system of care for youth with emotional and behavioral challenges and their families, through the involvement of caregivers, youth, youth serving agencies, and community representatives. Through enhanced coordination of system partners, the CIACC also identifies service and resource gaps and priorities for resource development.

Key CIACC functions include:

1. Evaluating the local county policies and practices to understand and minimize the impact of local barriers to serving youth in their home communities
2. Identifying local strategies and mechanisms to promote the integration and coordination of county, State, and other resources serving youth
3. Assessing local system needs using information received from CSOC, the CSA, any youth serving agency identified by CSOC, and other bodies to make recommendations regarding service and resource development priorities
4. Identify and inform CSOC regarding gaps and barriers to local service effectiveness

5. Providing input to State, regional, and county entities regarding system performance and service needs

II. In Home/In Community Providers (IIC, BA, IIH)

When youth involved with the CMO receive these services, they are an integral component of the CFT, and their attendance/participation in the CFT is mandatory. Partnership and ongoing communication with all members of the CFT, including timely response and documentation, is essential to help the family achieve their vision. Care Managers are required to reach out to these providers weekly for progress updates, and IIC providers are expected to reach out to the CFT with updates as indicated.

Coordination happens on the system level, as well as on the individual/CFT level. Every CMO has a process for training and orienting and providing updates to in home/in community providers.

Agencies providing IIC and BA services are required to sign a Memorandum of Understanding (MOU) with the CMO, which is a formal agreement that outlines the working relationship between the providers and the CMO, which may include referral processes, documentation requirements, and CFT attendance. Anything outside of the parameters of the MOU can be discussed in the context of the CFT or, if necessary, an internal CMO process. MOUs are reviewed annually.

Agencies providing IIH services contract with CSOC to provide three levels of IIH services. CSOC has defined practice guidelines for CMOs for accessing IIH services for CMO youth. The Practice Guidelines for Care Management Organizations Serving Youth with Intellectual and/or Developmental Disabilities and Serious Behavioral Challenges can be found in Appendix C. CMs should follow these guidelines when seeking IIH services.

III. Children's Crisis Intervention Services (CCIS)

CCIS is a regional acute care psychiatric inpatient crisis intervention and treatment services unit designated by the Commissioner of the Department of Health to serve youth from the ages of 5 to 17 years who have:

- Received an initial screening by a certified mental health emergency screening center
- A primary psychiatric diagnosis (including Acute Psychosis; Severe Depression with the potential for suicide, or the inability to adequately respond to treatment on an outpatient basis; behavior which poses a potential for suicide or the inability to adequately respond to treatment on an outpatient basis; dually diagnosed youth with a primary diagnosis of an acute psychiatric disorder and a secondary diagnosis of substance use or intellectual disability)
- An impaired level of personal and social functioning to the extent that inpatient psychiatric crisis intervention and treatment services are necessary

The CCIS provides assessment, crisis stabilization, evaluation, and treatment to youth in need of inpatient hospital admission who are either eligible for parental admission, voluntary admission or involuntary commitment.

CMOs are expected to build relationships with CCIS units and to have a process in place by which they are informed as soon as possible when a CMO involved youth is admitted to a CCIS Unit. CMs should also have prior discussion with families about the support available to them should the youth experience a crisis and the importance of the family communicating with the CMO if the youth is admitted to a CCIS. CMs should convene an Emergency CFT to address the emergent needs of the youth and family. Once a youth is admitted, CMs are required to visit the youth, maintain contact with the family, and hold CFTs, which include CCIS representatives, as driven by need. CCIS Units are acute in nature, and transition planning should be done with a sense of urgency to ensure that as soon as appropriate, the youth transitions to the intensity of service that meets the youth's needs.

CMOs encourage CCIS to participate in local CIACC and/or the Adult Mental Health System Review Committee, and to coordinate referrals to OOH treatment for CMO youth admitted to CCIS when necessary.

See below for coordination with civil commitment court as it relates to CCIS.

In addition to state designated CCIS units, there are private psychiatric hospitals that serve youth. CMs are expected to coordinate care for youth in these settings in the same way that they coordinate with CCIS units.

IV. Intermediate Inpatient Units

The Intermediate Inpatient Unit (IIU) is a sub-acute, psychiatric inpatient unit licensed as a closed child/adolescent inpatient unit by the Department of Health and Senior Services, and located in a community hospital. These units provide 24 hour mental health treatment and serve youth who require additional inpatient treatment following stabilization on a CCIS unit.

The youth has not yet reached his/her baseline function required to transition him/her back into the community, and requires less intensive care than the acute inpatient psychiatric unit but more intensive care than community residential programs. The IIU provides, but is not limited to:

- Multidisciplinary evaluation
- Medication management
- Individual/family therapy
- Group therapy
- Parent and family supports
- Daily living skill support

Referrals are made to IIU exclusively by the CCIS. However, the need for this service for youth involved with the CMO should be discussed within the context of the CFT. Once a youth is

admitted to an IIU, CMs should support the youth and family in the transition to IIU, and are required to visit the youth, maintain contact with the family, and hold CFTs, which include IIU representatives, as driven by need. IIUs are acute in nature, and transition planning should be done with a sense of urgency to ensure that as soon as appropriate, the youth transitions to the intensity of service that meets the youth's needs.

V. Court Systems

In the course of their work, Care Managers may need to engage with court systems, and must have an understanding of court processes and expectations. They are expected to work collaboratively and cooperatively with court representatives and provide a voice for the CFT, while educating court partners on the Children's System of Care.

Please note that this section may use the term "juvenile" instead of youth or young adult to be consistent with the language used in Juvenile Court processes and policies. The term "juvenile" is used to differentiate juvenile court from adult or criminal court.

a. Introduction to New Jersey Superior Court

Matters involving criminal, civil, and family law are heard in the Superior Court. There is a Superior Court in each of New Jersey's 21 counties, grouped into 15 vicinages that mirror CSOC's 15 service areas.

NJ Superior Court has multiple divisions, including the Family Division and the Civil Division. The Family Division of Superior Court handles all family related matters, such as those involving divorce, domestic violence, juvenile delinquency, child support, foster-care placements, and termination of parental rights. About 350,000 cases are handled by the Family Division each year. The Family Division in each vicinage consists of a Presiding Judge, Family Division Manager, Assistant Division Managers, Court Team Leaders, and support staff. The Family Division is complex, encompassing eleven different docket types.

The most frequent court hearing types for CMO involved youth are:

- Juvenile Delinquency (FJ Docket) - Superior Court, Family Division
- Family Crisis Petition (FF Docket) - Superior Court, Family Division
- Children In Court (Multiple Dockets, including FN, which involves youth whom DCP&P has removed from their family home) - Superior Court, Family Division
- Civil Commitment Hearings - Superior Court, Civil Division

Below are details on the most common docket types we see with CMO involved youth.

b. Overview of Juvenile Delinquency Docket

Juvenile Delinquency Court is rehabilitative in nature and time limited. The Court is required to hold hearings for youth and young adults charged as delinquents, within specific mandated time

limitations, particularly regarding youth/young adults held in secure detention (N.J.S.A. 2A:4A-38). Juvenile Delinquency matters are handled to preserve the unity of the family whenever possible, to protect the public interest, to prevent youth/young adults from committing further delinquent acts, and to provide appropriate services to youth to aid in their rehabilitation. Delinquency matters are managed in several ways.

The following persons typically attend Juvenile Delinquency Court hearings:

Public Defender, Juvenile Defense Services, Office of the Public Defender (OPD)

Youth accused of a juvenile delinquency offense are entitled to legal counsel. These legal services for youth and young adults, referred to as trial services, are provided through their regional Office of the Public Defender (OPD). Defendants without private legal representation who are approved by the courts to receive a public defender are referred to the county OPD for assignment of an attorney. Contrary to popular belief, representation is not entirely free. A fee is imposed on those families able to make payment at the end of the representation. Families not eligible for OPD services are required to obtain private legal representation for their youth.

To provide the best representation to juvenile clients, the NJ OPD's Office of Juvenile Defense Services works to enhance training and coordination among the juvenile attorneys located in each trial region. Among the office's efforts is an emphasis on getting juvenile clients the social services they need to avoid future contacts with the law. For more information on the Office of the Public Defender, go to <http://www.state.nj.us/defender/>.

Chief County Prosecutor's Office

Under New Jersey law, the County Prosecutor functions as the chief law enforcement officer for the county. Each County Prosecutor is charged with the prosecution of all juvenile delinquency cases scheduled on the formal court calendar in Family Court. Each county has a Chief County Prosecutor to whom all County Prosecutors report. There are dedicated Assistant Prosecutors assigned to each Juvenile Delinquency Court. The prosecutors represent the victims and their role is to ensure that the community is protected.

Juvenile Probation Services

Probation is a form of youth supervision, which is a potential outcome of delinquency proceedings in the Family Division. Probation offers youth with delinquency charges the opportunity to remain in their own community under supervision by a probation officer who monitors their compliance with the rules and conditions imposed by the Family Court Judge. These conditions may include completing treatment, paying restitution and fines, and achieving educational goals. The probation officer works with the parent/guardian, treatment providers, and school to ensure that the youth or young adult successfully completes the terms and conditions of probation. Probation supervision ends if a youth is sentenced to a term of incarceration in a JJC facility.

Juvenile Parole Services

When a youth serving a term of incarceration in a JJC facility nears the end of his/her sentence, the parole board may determine that he/she can be released to the community prior to the end of his/her sentence, at which point parole will supervise the youth through the end of his/her sentence. The parole board determines the youth's release date and stipulations of the youth's release. The parole board may mandate treatment. JJC will then submit updated clinical evaluations and Needs Assessments to the CSA for an appropriate IOS determination. If the youth is assigned to a CMO, the Care Manager should coordinate with the parole system representative when coordinating the CFT and planning for youth's needs.

CMO Role in Juvenile Court

Youth may become involved with Juvenile Court when they are arrested or involved with FCIU. When the CMO becomes aware that a youth they are serving has been arrested, whether detained or released into the community pending the hearing date, the CMO follows the CFT process, and should request an Emergency CFT Meeting as they would whenever the youth has a new behavior or need in order to revise the ISP.

Youth who are arrested and detained will have an initial detention hearing the following business day. It is important for the CMO to be aware as early as possible so that the CFT can convene and address the emergent needs as described in Section 5. CMOs must have a process by which they are made aware of any CMO enrolled youth remanded to a Juvenile Detention Center (JDC). A list of JDC facilities can be found at <http://www.nj.gov/oag/jjc/facilities.html>. CMOs are expected to collaborate with local detention center representatives to ensure this process is in place. CMOs have a dedicated court liaison (or one who provides this role) who can provide support and guidance to court partners around coordination and collaboration and CSOC processes, both on the individual level and on the system level. The CM is expected to attend the youth's initial hearing and reassure the court that the CFT will meet to address the new behavior and identify resources to address the needs of the youth, including community safety. .

As long as youth remains in a JDC, hearings will be held every two weeks. Hearings are scheduled at regular intervals for youth released into the community pending the next hearing.

Whether the youth is in the detention center or released to the community pending the next hearing, the CMO CM or other CMO designee is responsible to gather all relevant information, including court dates, court orders, and charges against the youth and to provide detailed updated status reports to the court. These reports should include actions taken, dates of actions taken, persons contacted, status of referrals, services implemented with the youth, and, where appropriate, efforts towards obtaining the needed services to transition the youth back home or to an out of home treatment program. Whenever there is a reference to CFT decisions, the status report will identify relevant members of the CFT. Status reports must also specifically address related court orders. Court orders can vary significantly, and CMs should seek supervision when providing reports to the court as per agency policy.

The CM or designee attends court and advocates for the newly developed ISP, which should include strategies that address the behavior, supervision, and treatment needs. This advocacy is imperative as the court relies on the CMO to communicate the results of the CFT meeting, including the team's identification of the youth and family needs and the plan to address those needs in order to stabilize the youth and reduce community safety concerns. The CFT creative process allows the CFT to come up with a newly developed individualized service plan that includes how added supervision and activities may address community safety concerns. While court orders should be discussed in the CFT planning process, court orders do not drive the planning process. CMs should be proactive in communicating CFT plans through the court reports to help guide the court orders to be consistent with the youth's clinical needs. As outlined in Section 5, an ISP includes appropriate clinical interventions; identifies community resources, such as after school programs or any other added supervision that may be needed; and addresses educational needs. Concrete reports and tools, such as a 24 Hour Clock or calendar, are helpful in demonstrating that community safety concerns have been addressed. A 24 Hour Clock or calendar will outline supports and services provided to the youth throughout each hour of each day of the week, and can demonstrate that supports and services in the youth's home and community are as intense or more intense than the youth would receive in an OOH setting. This can facilitate the court's agreement with a community plan even when the current court order or plea agreement stipulates OOH treatment. See the Tool Kit (in development) for more information on the calendar. When barriers to necessary supports or services exist, the CMO will present to the court progress toward overcoming barriers and creatively addressing needs through the CFT process.

According to the Juvenile Justice Statute, a judge may order a 14-day plan when a youth who is not involved with the CMO presents with emotional/behavioral health challenges during their court involvement. Although the statute describes the 14 day plan as a dispositional option, the 14 day plan protocol, created with the AOC in 2005 and updated in 2009, encourages the Judge to order the 14 day plan at any point in the legal process, once a youth presents with behavioral concerns. The goal is to identify and implement necessary interventions for youth with behavioral health needs at the earliest possible time to ensure the best outcomes.

The CMO is responsible for conducting the 14 Day Plan Process. The CMO assesses the youth and provides a report to the court that identifies service needs. Care Managers should present the service plan to the defense attorney/court as soon as it is developed and not wait for the next court hearing. According to Eddie's Law, reports or records relating to mental health services provided to a juvenile may only be provided (prior to adjudication; guilty/not guilty/etc.) to the youth's defense attorney. The defense attorney may choose to share information with the judge with the consent of the youth. Once the youth is adjudicated, this clinical information may be shared directly with the judge.

The 14 Day Plan assessment may indicate the youth has needs that require CMO intervention or other intensive services, or that the youth would be better served with outpatient services. The Court can incorporate the identified services into the disposition. The legal system has a responsibility to resolve pending charges against youth, regardless of concurrent behavioral

health planning. However, this planning assists the court in understanding the context of the youth's charge, and can inform the disposition.

The defense attorney's role is to achieve dispositions that keep youth out of jail and find the least restrictive setting that meets the youth's needs. However, in order to avoid a term of incarceration, the defense attorney may request an out of home treatment program, based on the youth's need. Even when the defense attorney requests OOH treatment, the CMO, in the context of the CFT, should actively work to develop concurrently a community-based plan, when clinically appropriate. The community-based plan must address the court's concerns about community safety. Including details about how the youth will be supervised by relatives or community programs, such as after school activities and/or a mentor, increase the likelihood that the court will accept the community based plan. A 24-hour schedule that clearly details the youth's supervision, treatment, and activities is most effective in advocating for youth to remain in the community. When a community plan is not accepted by the court, and a youth can benefit from and meets clinical criteria for out of home treatment, the CFT will follow the OOH Referral Process outlined in Section 7: Out of Home Treatment. Although it is preferable for a youth to have a disposition prior to entering an OOH treatment setting, it is not required. If a youth does not have a disposition prior to entering an OOH treatment program, CMs should collaborate with the court system partners to ensure that the youth's charges are resolved in a timely manner.

When a youth's charges are resolved, the youth will receive a legal disposition. This disposition is documented in a Juvenile Court order. Judges commonly order a term of probation with special conditions at disposition. Therefore, the Care Manager should always encourage the family to include the probation officer as part of the CFT to increase the collaboration across systems and the overall effectiveness of both plans.

CSOC has established several protocols to increase collaboration with the courts, both at the individual level and the system level. These protocols discuss the importance of including probation as part of the CFT and ensure the understanding of the Transitional Joint Care Review (TJCR) process, which describes how programs will maintain youth pending transition from one program to another once the CFT determines youth is in need of a different intensity of service. This helps keep the focus on therapeutic interventions and CFT planning rather than legal interventions. See Section 7: Out of Home Treatment for a full description of TJCR process. Following the SPEC protocol has significantly reduced the number of youth returning to detention on a Violation of Probation (VOP) simply to await another program, as well as significantly reduced the number of youth returning to a juvenile detention center due to program failure simply to await another program.

In addition to CSOC Protocols, each CMO must have a process by which they become aware of and obtain new court orders. Some CMOs have a dedicated court liaison or systems liaison to perform this function.

Tracking youth in detention:

It is widely known that a single stay in Detention is not only traumatizing to a youth but leads to increased likelihood of recidivism and other negative outcomes. The CFT planning process must be timely and have a sense of urgency for youth in detention given the negative outcomes associated with detention episodes. The Court often relies on supports and services coordinated by the CMO to assist the youth with a successful return to the community and may delay a disposition until the CMO obtains the appropriate services (e.g., OOH), therefore CFT coordinated services should be obtained on an expedited basis. The youth's length of stay in detention is tracked through the Juvenile Detention Alternative Initiative (JDAI) process by the AOC.

The Court will expect updated status reports at each court hearing. The status report should include efforts towards obtaining appropriate services for youth's safe return to the community. It is important for the CM to be aware of the court hearings in order to provide the status reports to aid in the court's decision making process.

CSOC has a dedicated staff to track CMO involved youth in detention awaiting OOH. A report showing youth remaining in detention post disposition (so youth is only in Detention awaiting CSOC OOH) is created each week and sent to DCF executive management. In addition, youth within DCP&P custody MUST be released from JDC within 30 days of disposition.

If the plan is OOH treatment, then the CFT should consider a referral to the CSOC gatekeeper for the Detention Alternative Program (DAP).

Detention Furlough beds:

Sometimes a court may furlough a youth to the shelter to avoid having him/her go to detention and have him or her go to an option that is time limited (up to 30 days) and less restricted, or if family challenges prevent the youth from returning home. Funding for these beds is not provided through the CSOC or CMO, and coordination and collaboration with the court system is the same as described above with the goal of returning the youth to the community or planning for the youth's needs. CMs will work within the CFT to coordinate necessary supports and services as quickly as possible. For youth in need of a BPS, CM will follow the Expedited BPS Process as referenced in the JJC Best Practices Guidelines.

Responding to Juvenile Court Orders

As referenced above, the CMO should have a process in place to ensure it is receiving court orders involving youth they serve. Care Managers need to understand how to read and interpret court orders in order to understand the youth's adjudication status, to facilitate the CFT planning for the youth, and to respond to the court. The FAQs on the 14 day plan, which can be found at <http://www.state.nj.us/dcf/documents/behavioral/providers/14dayFAQ.pdf>, also contain helpful information on responding to court orders.

CMOs must complete certain tasks to respond effectively to a court order.

- Always obtain a copy of the court order to ensure you are aware of the content of the actual order to avoid misunderstandings.

- CMO must comply with the court order or approach the judge to explain respectfully the reason(s) the court order cannot be followed. For example, when a psychiatric evaluation is ordered but current one exists. When possible and appropriate, the CMO should provide a recommended course of action. Advising the court that an order cannot be followed without efforts to address the underlying issues and/or offering alternatives may result in a more problematic court order and may damage the CMO's and CSOC's collaborative relationship with the court. For example, if a judge orders CMO to provide services to a youth who is not open and/or eligible for CMO, offers suggestions on how that youth may obtain the needed service.
- If a problematic court order is originating from a request to the judge by the prosecutor or defense attorney, the CMO should approach this party to determine their goal(s) in this area and discuss mutually agreed upon alternatives that can resolve the issue. This will result in the best possible outcome for the youth and build a more collaborative relationship with the court.
- Court reports should describe specific details of the planned services, steps taken toward implementation of the plan, and how the plan addresses community safety. Having a copy of the court order ensures the CFT addresses all needs prior to the subsequent court hearing. Court reports must demonstrate to the court that CMO is managing the youth's care. While it is important to advise the court of barriers, the CMO must also gain the court's confidence that there is a plan to move beyond these obstacles and obtain the most appropriate supports and services for the youth.
- Clear communication with collaborative partners, such as DCP&P, the CSOC CSA, SRTU, contracted OOH providers, is critical to demonstrate the CMO is developing a unified plan. Any disagreements must be worked out before a plan is presented to the court.
- The court report should be provided two days prior to the hearing to the defense attorney prior to adjudication. For post adjudicated matters, the report can be provided to the prosecutor and Judge, as well as the defense attorney. Some vicinages allow for oral reports during the court hearing.

Collaborating Outside of the Juvenile Court

- **Unified DCF Plan**
If DCP&P is also involved with a court involved youth, DCF must present a unified plan to the court for the best outcome for the youth and family. Effective collaboration with system partners, including but not limited to DCP&P, CSOC CSA, SRTU, and contracted OOH providers, requires the CMO team to work out issues before court and not use the court hearing to resolve system disputes and/or blame other entities, which result in problematic court orders.
- **Participation in Local Court Related Meetings**
Established local CMO/DCP&P meetings should be used to identify youth who are dually involved, so planning can start in advance of a court matter. Care Managers and/or

Court/System Liaisons should alert CMO administration of problematic issues so they can be addressed at local court meetings, such as Local JDAI, MDTs, and CIC meetings. See ED/Administrator system responsibilities.

- **CSOC Liaisons**
CSOC provides a full time staff who acts as a Liaison to Detention. CSOC Court Liaison duties include: track youth on post dispositional status awaiting OOH treatment; serve as gatekeeper to Detention Alternative Programs; utilization management of the DAP programs, provide training on a cyclical basis to Court Liaisons, provide guidance/troubleshooting to care managers, attend local MDT and other planning meetings, as requested.
- CSOC also has a Liaison to Juvenile Justice and a Liaison to the Judiciary. These Liaisons provide education to the court and judiciary at a statewide level. While these Liaisons act as the single point of contact between CSOC and members of the juvenile court and judiciary, the CMO is responsible for addressing youth specific and local matters. CMOs are expected to develop and support local efforts to educate and problem solve with the court systems through attendance at standing and ad hoc meetings, as well as through establishing formal and informal communication paths.

Prior to contacting the CSOC court liaison for assistance with any juvenile court related issue, CMO administration should ensure all practice elements of their work have been completed. This includes providing supervision and seeking administrative guidance at the ED level. The ED plays an important role in relationship development with court partners to assist them in understanding how families and youth best engage with supports and services and to assist the court in trusting the families to engage and allowing them to be supported by their involved systems which gives youth and families the opportunity for the best outcomes.

If reasonable efforts have been taken to address problematic court orders without success, CMO Executive Directors and/or Directors of Operations serve as the points of contact with the CSOC Liaison to the Judiciary for consultation. The CMO should be prepared to provide evidence of activity already undertaken in their efforts to resolve the matter.

c. Overview of Children in Court Dockets

There are several types of hearings/dockets that fall under Children in Court. Most of the Children in Court (CIC) hearings relevant to Care Managers are under the Abuse and Neglect Docket (FN). Other Family Division docket types include Dissolution (FM) (Matrimonial), Non-Dissolution (FD) (custody, visitation, child support when dissolution of a marriage is not an issue); Domestic Violence (FV); Domestic Violence Violations (FO); Termination of Parental Rights (FG); Kinship & Legal Guardianship (FL) and Adoption (FA). Although the litigation in these docket types does not focus on the youth, the judge may order DCF to provide treatment services.

In addition to the assigned/designated DCP&P staff, the following parties appear at CIC hearings:

Deputy Attorney General (DAG): DAGs are located in the Office of the Attorney General, Division of Law. The DCF Practice Group, headed by the Assistant Attorney General in charge of DCF Matters, consists of four geographic sections, which provide representation to the Department of Children and Families (DCF) in cases where DCF is seeking supervision of abused and neglected children, seeking termination of parental rights, or has an interest in the outcome of a particular court matter.

Law Guardian: In child welfare cases in New Jersey, children and youth have rights separate and distinct from those of their parents or guardians. One important right a youth has is the right to have an attorney present to represent the youth's wishes to the judge, and protect the youth's interests throughout the legal proceedings. Located within the NJ OPD, the Office of Law Guardian (OLG) is responsible for providing this legal representation to youth in family court matters involving allegations of abuse and neglect against parents or other caregivers, or in cases involving possible termination of parental rights.

A Law Guardian helps the youth understand his/her legal rights and the court process, and keeps the youth informed as the case progresses through the child welfare system. The Law Guardian counsels the child, gives legal advice about the most realistic course of action to protect the youth's safety and advance the youth's wishes and interests, and helps the youth participate fully in court hearings.

The OLG has staff attorneys throughout the state assigned to represent children in child welfare matters.

Parental Representatives: Parents charged in abuse and neglect cases, or those facing the loss of parental rights, are entitled to counsel through the NJ OPD, Office of Parental Representation (OPR). With family reunification as the ultimate goal, OPR works to provide the highest quality defense for affected parents to keep families intact in Title 9 (Abuse and Neglect) and Title 30 (DCP&P Care and Supervision) matters. Staff and pool attorneys work to ensure proper services are put in place so that affected parents acquire the skills needed to make reunification successful. For more information go to <http://www.state.nj.us/defender/>.

Court Appointed Special Advocates (CASA): CASA affiliates recruit and train community volunteers to be a "voice in court" for youth removed from their homes due to abuse and/or neglect. These advocates "speak up" for these youth, helping them get the services they need and ensuring that they find safe, permanent homes. CASA programs operate in all 21 counties in New Jersey and more than 1,800 CASA volunteers served over 3,000 youth in 2015. More information is available at www.casaofnj.org.

CMO Role in Children in Court Hearings

In Abuse and Neglect matters, the parent(s)/legal guardian are the defendants. However, in this and other CIC hearings, the judge orders DCF to provide appropriate treatment services to the youth. If CMO is involved, DCP&P will be required to obtain status updates on treatment services and provide this information to the court. Ideally, the DCP&P Caseworker obtains this information during FTM/CFT Meetings and treatment meetings (ideally these meetings are combined). However, if a more detailed update is indicated, CMO will submit a written report to DCP&P.

Court reports must demonstrate to the court that CMO is managing the youth's care. While it is important to advise the court of barriers, the CMO must also gain the court's confidence that CMO has a plan to move beyond these obstacles and obtain the most appropriate supports and services for the youth. Clear communication with DCP&P is critical to demonstrate that DCF is developing a unified plan.

In most circumstances, CMO should not be required to testify in Family Court if the Care Manager works with the DCP&P Caseworker to ensure DAG has all the necessary information in their report to the court. Since the DCP&P Caseworker attends all CFTs, he/she will be able to respond to most questions about the plan, proposed treatment interventions, etc. CMO administration should establish the collaborative planning process with Area Offices and address barriers to communication before CMOs are court ordered to testify. Please note that further details in support of this process are under development and will be incorporated into this document upon completion.

Responding to Children in Court Orders

All CIC court orders contain the names of the assigned Law Guardian, DAG, family members, and next court date. The initial court order in these matters appoints the Law Guardian, and is titled the *Order to Show Cause and to Appoint a Law Guardian With Temporary Custody*. Among its other provisions, this order entitles the Law Guardian to have access to, and to obtain copies of, all records, including but not limited to, medical, mental health, school, drug or alcohol treatment and other records and/or information concerning his/her client. This court order is always provided to DCP&P. Care Managers should understand the role of the Law Guardian; that he/she is, in the eyes of the law, the legal representative of the youth. The Law Guardian is legally entitled/mandated to ask questions and receive answers about the youth's care. Any information shared with the Law Guardian must simultaneously be shared with the DAG. Further details in support of this communication process are under development and will be incorporated into this document upon completion.

The CMO must have a process in place to ensure it is receiving court orders involving the youth under its care. Care Managers need to understand how to read and interpret court orders in order to facilitate the CFTs planning for the youth and to respond to the court.

CMOs must complete certain tasks to respond effectively to a court order.

- Always obtain a copy of the court order to ensure you are aware of the content of the actual order to avoid misunderstandings.
- CMO must comply with the court order or approach the judge to explain respectfully the reason(s) the court order cannot be followed. For example, when a psychiatric evaluation is ordered but current one exists. When possible and appropriate, the CMO should provide a recommended course of action. Advising the court that an order cannot be followed, without efforts to address the underlying issues and/or offering alternatives, may result in a more problematic court order and damages CMO's and CSOC's collaborative relationship with the court. For example, if a judge orders CMO to provide services to a youth that are not available through the CMO, the CMO must offer suggestions on how that youth may obtain the needed service.
- If a problematic court order is originating from a request to the judge by an interested party, such as a Law Guardian, the CMO should approach DCP&P and/or the DAG to determine the parties' goal(s) in this area and discuss mutually agreed upon alternatives that can resolve the issue(s). This will result in the best possible outcome for the youth and build a more collaborative relationship with the court.
- Court reports should describe specific details of the planned services, steps taken toward implementation of the plan, and how the plan addresses community safety. Having a copy of the court order ensures the CFT addresses all needs prior to the subsequent court hearing. Court reports must demonstrate to the court that CMO is managing the youth's care. While it is important to advise the court of barriers, the CMO must also gain the court's confidence that CMO has a plan to move beyond these obstacles and obtain the most appropriate supports and services for the youth.
- Clear communication with collaborative partners, such as DCP&P, CSOC CSA, SRTU, and contracted OOH providers, is critical to demonstrate the CMO is developing a unified plan. Any disagreements must be worked out **before** a plan is presented to the court.
- The court report should be provided to DCP&P and the DAG at least five days prior to the hearing.

Since the DCP&P Case Worker is a member of the Child Family Team, the DCP&P Case Worker will be aware of clinical recommendations and the goals developed by the CFT. If a Law Guardian does question clinical recommendations, services plans, etc., the CMO Care Manager or Supervisor should notify, and discuss the matter with, the DCP&P Area and/or Local Office staff.

Pursuant to N.J.S.A. 30:4-24.3, records held by CSOC and its system partners may only be disclosed in response to a court order, or the consent of the individual whose records are at issue. Therefore, if a Law Guardian seeks access to the youth's record, he or she must present either the *Civil Action Order to Show Cause for Temporary Custody*, or an appropriately executed release of information. **CMO and other system partners are prohibited from releasing records in response to a subpoena issued by an attorney or other entity.**

Rather than simply releasing a record without discussion, the CMO Care Manager or Supervisor should always engage the Law Guardian, via the DAG when indicated, in discussion. Below are specific recommended steps to follow if a Law Guardian requests the youth's records:

- a. CMO should offer a written report that provides details on all aspects of the youth's clinical needs and current services.
- b. If there are still questions/concerns, CMO should offer a telephonic conference with the CMO Supervisor to discuss the court report and to address any questions and concerns. The DCP&P Case Worker and DAG should be included in the conference whenever possible. The conference is an opportunity to educate further the parties on the youth's clinical needs, role of the CFT and treatment options, as well as the CSOC Out-of-Home Treatment process.
- c. If these discussions result in the CMO receiving details/information not included in past CFT discussions, the CMO will offer to reconvene the CFT to determine how the additional information may impact the IOS and the CFT recommendations.
- d. If the above recommended actions are not successful and/or if the court orders a release of records, the Order should be written for CMO, not the CSA, to release the relevant records.

Collaborating Outside of Children in Court Hearings

- **Unified DCF Plan**
If DCP&P is involved, DCF must present a unified plan within the courtroom for best outcome for youth and family. Effective collaboration with system partners, including DCP&P, CSOC CSA, SRTU, contracted OOH providers, etc. requires the CMO team to work out issues before court and not use the court hearing to resolve system disputes and/or blaming other entities, which result in problematic court orders.
- **Participation in Local Related Meetings**
Established local CMO/DCP&P meetings should be used to identify youth who are dually involved, so planning can start in advance of a court matter. Care Managers and/or Court/System Liaisons should alert CMO administration of problematic issues so they can be addressed at local court meetings, such as Local JDAI, MDTs, and CIC meetings. See ED/Administrator system responsibilities.
- **CSOC Liaison**
CSOC's Liaison to the Judiciary is the single point of contact between CSOC and the judiciary and provides education regarding philosophy, structure, and practice to CIC court partners at a statewide system level. The Liaison manages orders involving CSOC CSA and CSOC division representatives. The CMO is responsible for addressing youth specific and local CIC matters as well as developing and supporting local efforts to educate and problem solve with the court systems. CMO's accomplish this through attendance at standing and ad hoc meetings, as well as through formal and informal communication paths.

Prior to contacting the CSOC court liaison for assistance with any CIC, CMO administration should ensure all practice elements of their work have been completed. This includes ensuring supervision has occurred and administrative guidance at the ED level has been sought.

If reasonable efforts have been taken to address problematic court orders without success, CMO Executive Directors and/or Directors of Operations serve as the points of contact with the CSOC Liaison to the Judiciary for consultation. The CMO should be prepared to provide evidence of activity.

d. Overview of Civil Commitment Docket

All psychiatric patients who are in the hospital longer than fourteen days are required to appear before a judge. These hearings, by law, must be held within 14 days of confinement for a minor (*R. 4:74-7A(c)* (6) and 20 days of confinement for an adult (*N.J.S.A. 30:4-27.12*). This brief hearing focuses on the patient's legal rights within the context of hospital treatment. See 4:74-7A. Civil Commitment-Minors - <http://www.njcourts.gov/attorneys/assets/rules/r4-74.pdf>

Hearings occur at all psychiatric inpatient units, including CCIS Units, private Adult & Child/Adolescent Units, and Adult State & County Psychiatric Hospitals.

In addition to hospital/CCIS staff, the following persons typically attend Civil Commitment Hearings:

Mental Health Advocacy, Office of the Public Defender

The Division of Mental Health Advocacy assists people who have a mental illness or who are receiving mental health services. The division represents individuals who are facing commitment or denial of liberty, sexually violent predator commitments, and guardianship for people with developmental disabilities under state civil law. In commitment hearings, their role is to ensure an individual is released from the hospital to the least restrictive setting as soon as it is safe to do so.

County Adjuster's Office is a statutory office (New Jersey Statute 30:4-34) authorized to act in cases of commitments or admission of persons to State, County or private hospitals for the mentally ill. The County Adjuster is responsible for the scheduling of court hearings for anyone with mental illness admitted to a state, county or private psychiatric hospital. Each county is responsible to cover the cost of care for its residents. The County Adjuster, acting as referee of the Court, investigates the residency and "ability to pay" of those admitted to these hospitals and reports those findings to the Superior Court. The Superior Court then issues an Order, which indicates if a particular county or the State of New Jersey is financially responsible and the amount, if any, the patient or relative is responsible to pay. Anyone admitted to a state or county facility remains liable for his or her full cost of care.

CMO Role in Civil Commitment Court

Care Managers should attend all commitment hearings for their assigned youth and demonstrate to the court that CMO continues to plan for the youth's care. While it is important to advise the court of barriers, the CMO must also gain the court's confidence that the team has a plan to move beyond these obstacles and obtain the most appropriate services for the youth. If DCP&P is involved, clear communication is critical to demonstrate that CMO and DCP&P are developing a unified plan.

Upon learning that a youth has been admitted to a psychiatric unit, the CMO follows the CFT process and should initiate an Emergency CFT Meeting, as they would whenever the youth has a new behavior or need in order to revise the ISP. The Care Manager conducts face to face visits and attends court to advocate for the newly developed plan that addresses the behavior, supervision, and treatment needs. This advocacy is imperative as the court relies on the CMO to communicate the results of the CFT meeting, including the team's identification of the youth and family needs and the plan to address those needs in order to reduce safety concerns. The CFT creative process allows the CFT to come up with a newly developed individualized service plan that includes how added supervision/activities may address safety concerns. As outlined in Section 5, a service plan includes appropriate clinical interventions; identification of community resources, such as after school programs or any other added supervision that may be needed; and return to school.

The hospital treatment team may recommend out of home treatment program, based on safety concerns or other clinical issues. The CMO, in the context of the CFT, should actively work to develop concurrently a community-based plan when clinically appropriate. The community-based plan must address concerns about safety. Including details about how the youth will be supervised by relatives or community programs, such as after school activities and/or a mentor, is essential. A 24-hour schedule that clearly details the youth's supervision, treatment, and activities is most effective in advocating for youth to remain in the community.

If the CFT is recommending out of home treatment, the Care Manager must ensure timely gathering of all required material for the Out of Home Request and ensure that it is submitted in a timely manner. The Care Manager must clearly note in the OOH Request that the youth is in the hospital to ensure it is reviewed by CSA in one business day. If the IOS determination is PCH or SPEC, the Care Manager should immediately submit the required documentation to the SRTU to ensure timely receipt of a list of programs. Upon receipt of the program list, via SRTU or YouthLink, the Care Manager send packets to the designated programs and immediately advise them of the referral and that the youth is in the hospital to ensure a timely review.

Care Managers should not wait to hear from programs and should make daily phone AND email contact, if needed, until a meet and greet is scheduled. If a program remains unresponsive the Care Manager should immediately contact her/his supervisor and utilize the CMO and receiving agency communication chains until a meet and greet is secured. Care Manager should not advise a court that he/she has not received a return call/message. Rather, the Care Manager should make the necessary contacts prior to court. However, if this is not possible, Care Managers should assure the court that CMO has the capability to establish contact in a timely manner and secure a meet & greet. If an OOH program refuses a meet and greet or

determines they are unable to meet a youth's clinical needs, the Care Manager should ensure all necessary advocacy, via a supervisor, administrators, SRTU, etc., is conducted before accepting a refusal.

As long as youth remains in the hospital, hearings will be held every two to four weeks. While the youth is in the hospital, the CMO is expected to provide detailed updated status reports at each court hearing. These reports should include actions taken, dates of actions taken, persons contacted, status of referrals, services obtained for the youth and, where appropriate, efforts towards obtaining the needed services to transition the youth back home or to an out of home treatment program. Care Manager should not present problems and/or obstacles to the court without a clear plan to address these issues. Whenever there is a reference to CFT decisions, the status report will identify relevant members of the CFT. Status reports must also address related court orders.

Responding to Civil Commitment Court Orders

Always obtain a copy of the court order to ensure you are aware of the content of the actual order to avoid misunderstandings.

CMO must comply with a court order or approach the judge to explain respectfully the reason(s) the court order cannot be followed. For example, when a judge orders CMO to seek Out of Home treatment. When possible and appropriate, the CMO should provide a recommended course of action. CMO should ensure the CFT addresses all needs, as well relevant elements of the court order, prior to the next court hearing.

If a problematic court order is originating from a request to the judge by an interested party, such as an OPD Mental Health attorney, CMO should approach the attorney to determine the her/his goal(s) in this area and educate the attorney on the plan. This will result in the best possible outcome for the youth and build a more collaborative relationship with the court.

Collaborating outside of Civil Commitment Court

Unified Plan

Since CFT Meetings for youth in the hospital include hospital treatment team representatives, consensus should be established prior to court hearings.

If DCP&P is involved, DCF must present a unified plan within the courtroom for best outcome for youth and family. Effective collaboration with system partners, including but not limited to DCP&P, CSOC CSA, SRTU, and OOH providers, requires the CMO team to work out issues before court and not use the court hearing to resolve system disputes and/or blaming other entities, which result in problematic court orders.

CSOC Liaison

CSOC's Liaison to the Judiciary is the single point of contact between CSOC and the judiciary, the CMO is responsible for addressing youth specific and local matters. CSOC Liaison also provide education judiciary and other members of the various courts at a

statewide level. However, the CMO is responsible to educate the court on CSOC policies in civil commitment matters. This typically occurs as questions are raised when the Care Manager provides its update at the hearing.

Prior to contacting the CSOC court liaison for assistance with any civil commitment issue, CMO administration should ensure all practice elements of their work have been completed. This includes ensuring supervision has occurred and administrative guidance at the ED level has been sought.

If reasonable efforts have been taken to address problematic court orders without success, CMO Executive Directors and/or Directors of Operations serve as the points of contact with the CSOC Liaison to the Judiciary for consultation. The CMO should be prepared to provide evidence of activity.

VI. Family Crisis Intervention Units (FCIU)

FCIUs are legislatively mandated programs that provide timely response and intervention services to youth with urgent needs around truancy, runaway behavior, conflict with caregivers, and/or the youth's involvement in human trafficking. FCIUs exist in all NJ counties and are available 24 hours a day, seven days a week. FCIU initial contact is typically done telephonically with follow-up in-office intervention the next day. Follow-up is provided by the FCIU staff and/or by referral to another program with oversight by the FCIU. The referral source to a FCIU is generally through the police, the juvenile justice system, school, community, or self-referrals. Participation with FCIU is voluntary. However, court and law enforcement personnel have the ability to refer to FCIU without caregiver consent. Additionally, FCIU has the ability to petition the court when resources have been exhausted or the youth or family have not been engaged in treatment and with FCIU recommendations.

Some counties have elected to combine their FCIU program with their MRSS program. Combined programs follow DCF and CSOC policies, procedures, and regulations, and operate within the MRSS Program Model as outlined in Section 2. Combined units also follow statutes set forth in the Juvenile Family Crisis Intervention Unit Operations Manual, which can be found at <http://www.njcourts.gov/courts/assets/family/jfcopmanual.pdf>. Combined unit programs are able to accept referrals from court personnel and law enforcement officers without parental consent, and have the capability to petition the court when resources have been exhausted or the youth or family have not been engaged in treatment or with recommendations.

FCIU and combined units have access to two types of petitions: Juvenile Family Crisis Petition and the Out of Home Placement Petition. These two petitions are reserved for situations in which all other options and resources for managing crises have been exhausted. The Out of Home Placement Petition is used as a short-term strategy only when the youth can no longer be maintained in the home despite making every effort to support the youth and family in remaining together.

Rarely, CMO involved youth will become involved with FCIU or MRSS/FCIU combined units. This is always at the direction of the CFT after all other community options have been

exhausted and with supervisory consultation. CMOs will work locally to establish pathways of communication and coordination with the local FCIU programs on the individual and the system level, and CMOs will follow their local processes for accessing FCIU services.

VII. Division of Child Protection & Permanency (DCP&P)

The mission of DCP&P is to ensure the safety, permanency, and well-being of children and to support families. In accordance with N.J.S.A. 9:6-8, 10, 8.14 and 2C:43-3 and 8, anyone who has a reasonable suspicion of child abuse or neglect is required to report their suspicion to DCP&P through the State Central Registry at 877-NJ-ABUSE (877-652-2873). In the event a Care Manager has reason to suspect a youth is being abused or neglected, he or she should immediately consult their agency specific policy on reporting suspicion of abuse or neglect.

More information about reporting requirements is available at

<http://www.state.nj.us/dcf/reporting/>

DCP&P operates under a Practice Model which utilizes Family Team Meetings (FTM) to accomplish Engagement, Assessment, Planning, and Linkage. When youth are involved with both CMO and DCP&P, planning is done collaboratively. For mutually involved youth, the CFT and the DCP&P FTM are combined into one meeting. The CM is responsible to be in contact with Case Workers routinely, and/or DCP&P administration as appropriate, and to document all outreach activities around coordination of the CFT/FTM. DCP&P maintains the primary responsibility for DCP&P youth in planning for well-being, permanency, and situations of abuse and neglect. Where roles overlap (well-being or treatment needs), the CM and DCP&P Caseworker discuss, in the context of the CFT/FTM, the needs of the family, and coordinate which team members will be responsible for each strategy/resource, depending on the strengths and resources of each team member. Particular attention should be given to coordination for youth involved with DCP&P who are transitioning out of CMO services. CMs should ensure DCP&P is aware of the plan for a youth to transition from CMO services at the earliest possible time. Best practice for transition includes a joint CFT/FTM within 30 days of the anticipated transition date. There should minimally be a CMO supervisor to DCP&P supervisor conversation about the transition and this conversation should be documented in the EHR. DCP&P operates with the same standards regarding youth involved with CSOC transitioning from CP&P involvement. With regards to permanency planning, CMO representatives' role is to participate as a member of the CFT/FTM to assist in creating a long term sustainable plan for the youth to have meaningful connections with supportive adults, including primary caregivers, extended family, friends, community members, who will support the youth throughout their lifetime.

Each Area Office has an organization structure that includes the following, in ascending order of reporting:

1. Caseworker
2. Unit Supervisor
3. Casework Supervisor

4. Local Office Manager
5. Area Director
6. Division Director

As Caseworkers are often in the field, CMs are encouraged to reach out to Unit Supervisors or Casework Supervisors to expedite communication and collaboration with DCP&P with mutually involved families. CMs should consult with their executive staff to facilitate communication with Local Office Managers and/or Area Directors.

Clinical Consultants provide on-site consultation services to DCP&P, and who are supervised by local CMOs. The Clinical Consultant position was created as a collaboration between CSOC and DCP&P, and provides expertise, training, and guidance in response to the mental or behavioral health needs of youth and families served by DCP&P staff. They also provide education and guidance on the Values and Principles of CSOC. This guidance may take the form of reviewing or recommending psychological or psychiatric evaluations, crafting referral questions for evaluation, performing record reviews, and ultimately making recommendations regarding potential and appropriate interventions to improve the functioning of youth in the context of their families, address needs, and achieve positive outcomes from a behavioral and mental health perspective as well as a resolution perspective.

The DCP&P Team Leader sits in the Area Office and is the liaison between the DCP&P Local Office/Area Office and the CMO/CSOC. They are the point people in each county with access to the CSOC EHR. They provide education on DCP&P policy and procedures to CMO staff, as well as provide education on CSOC policy and procedures to DCP&P staff. They troubleshoot difficult situations with the CMO Operations Manager or Clinical Consultant, they schedule joint case conferences for dually involved youth, and they identify system issues that may be barriers to effective communication and service delivery. They also participate in local system collaboration meetings, including but not limited to CIACC, Multidisciplinary Meetings, and Juvenile Detention Alternative Initiatives. They facilitate referrals to resources such as ED RU and crisis stabilization beds if CSOC is not involved.

DCP&P has resources available to CMs for consultation and collaboration as needs arise such as Child Health Unit nurses and domestic violence liaisons. The Child Health Unit employs nurses who are assigned to work with youth in out of home treatment involved with DCP&P to assist with coordination of youth's health needs.

Domestic Violence Liaisons exist in each DCP&P area and are available in a consultant role when issues of domestic violence are identified. CM supervisors will coordinate a discussion with DCP&P regarding consultation with Domestic Violence Liaisons when consultation in the area of domestic violence is identified as a need.

In addition to the above, the DCP&P case workers have access to additional resources. CMs can work with their local Clinical Consultant around accessing these services.

In addition to coordination for specific youth outlined in Section 5, CMO and DCP&P representatives collaborate at the local systems level around global needs and coordination within forums such as CIACC, and Child Stat youth reviews.

a. DCP&P Access to Shelters

CMOs do not have access to shelters. CFTs have the responsibility to address housing needs, including emergency housing, by exploring every option possible. Options often exist in the youth's family and social contacts. CFT/FTM members can assist the youth in identifying and accessing these options. There are Family Court or FCIU shelters in some counties, referenced above under the Court System. There are federally funded or HUD shelters for homeless youth, who access these directly, with the assistance of their CMs. There are agencies which provide supportive services, including housing, to youth over 18. CMs can assist CMO youth in obtaining referrals to these agencies.

DCP&P has short-term shelter options available for use as a last resort when a youth who is age 13 or over is in need of emergency housing. DCP&P has a shelter placement protocol and tracking procedure for youth under the age of 18 in order to ensure appropriate utilization and care planning for those youth requiring shelter placement. This protocol outlines activities and administrative procedures to ensure all efforts to secure appropriate placement elsewhere have been exhausted and shelter stays are limited to 30 days unless so ordered by a judge. If the CMO is involved with a youth accessing a DCP&P shelter, the CMO is expected to coordinate with DCP&P through an expedited CFT meeting to identify more appropriate housing options.

b. Office of Adolescent Services (OAS)

The mission of OAS is to support adolescents transitioning to adulthood to achieve economic self-sufficiency and interdependence, and engage in healthy lifestyles by ensuring needed services are coordinated among service systems and offering supports and services youth need to thrive. CMO executive staff are invited to participate in ongoing collaboration efforts at regional OAS planning meetings. For more information on OAS, including Helping Youth Thrive principles, visit <http://www.nj.gov/dcf/about/divisions/oas/>.

The Adolescent Housing Hub at <http://www.nj.gov/dcf/about/divisions/oas/> is one of the programs managed by the Office of Adolescent Services of DCF. It is a real-time database designed to assist youth with living arrangements in transitional or permanent housing programs. These programs are accessed by contacting the CSA. The CSA will gather information about the youth, their current living situation, and need for housing. The youth's name is posted on the Hub, and the name and contact information for 3 housing programs that have immediate openings will be given to the youth for their follow up. Those programs will also have the youth's information and will outreach to the youth to arrange an interview.

These programs provide housing and are not considered treatment programs. They are not designed for youth with high levels of mental health needs. These programs may be options for youth who are transitioning from CMO services with a strong behavioral health plan in place but

are in need of housing. Currently, youth under 18 need to be involved with DCP&P to access these resources.

VIII. Screening Centers

Designated Screening Centers are psychiatric emergency service programs funded through DMAHS which offer services to individuals experiencing psychiatric crises. These programs offer 24 hour/day crisis intervention, assessment, and referral services. These programs offer both on-site and community outreach interventions. They are primarily designed to assess for inpatient hospitalization, and they are the initiator of involuntary commitment proceedings when appropriate. Those not appropriate for inpatient hospitalization are provided with referrals to other levels of care.

When a youth presents to a Screening Center, the Screening Center may contact the CSA to determine if the youth is already receiving services from CSOC. If a youth who presents at a Screening Center is already involved with the CMO, the CMO should be contacted for collateral information, collaboration, and coordination of care. The CM will gather information from the screening center about their assessment of the youth's needs and recommended strategies for intervention. The CM is expected to connect with the family and/or youth upon hearing the youth has been admitted to a screening center. The CM is responsible to coordinate necessary activities based on the youth's identified needs. This typically includes face to face visits and an emergency CFT. CMs will collaborate with the Screening Center on finding the most appropriate treatment to support the youth's needs as assessed and described by the screening center with relevant input from the CFT. CMs will seek supervision when planning for youth in screening centers if appropriate resources necessary to meet a youth's needs are not available in a timely manner.

CMOs are expected to develop pathways of communication and collaboration with designated psychiatric screening centers in their communities on a system level. This may involve them including a representative from screening on their local CIACC, ongoing, routine communication with agency and local hospital staff, and participating in local Acute Care System Review Committees which are coordinated by the screening centers.

Coordination activities can benefit from examining trends of youth served by screening centers and identifying strengths and barriers to coordinating their care. These system level relationships and activities can support planning and problem solving for individual youth when challenges arise. CMO Administration should be proactive in advocating for youth who are encounter system barriers such as reported lack of resource availability, insurance disputes, needing thorough description of youth's treatment needs, etc.

For a list of designated screening centers and their contact information, go to

http://www.state.nj.us/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf

IX. Division of Developmental Disabilities (DDD), including DDD Roundtable Transition Process

The Division of Developmental Disabilities (DDD), under the Department of Human Services (DHS), provides public funding for services and supports that assist New Jersey adults with intellectual and developmental disabilities ages 21 and older to live as independently as possible. Services and supports are available in the community from independent providers. DDD is responsible for making DD eligibility determinations for adults, including young adults aged 18-21.

CMO enrolled youth may have intellectual and/or developmental challenges that will require supports and services beyond their involvement with CSOC. Youth ages 18 and older are required to be determined DD eligible through DDD in order to access supports and services, even if they have been determined DD eligible through CSOC prior to their 18th birthday.

The CMO is expected to support families in applying for DD eligibility through DDD for youth ages 18 and older who need DD supports and services. Information on the application process is available at <http://www.state.nj.us/humanservices/ddd/services/apply/index.html> . The CM should begin this process as early as the need is identified, as part of the CFT's ongoing transition planning process, to ensure the most supportive, sustainable plan. Youth ages 18-21 who are determined eligible by DDD are served by CSOC through the day before their 21st birthday.

For youth who have DDD eligibility and are living in the community, the CFT should discuss options available through DDD for planning for adult supports and services, and CMs must support families in accessing DDD's supports program and/or support coordination programs to collaborate on necessary supports and services that will meet the youth adult's needs. Information on how to access these and other DDD programs is located at <http://www.state.nj.us/humanservices/ddd/home> .

For youth who have DDD eligibility and are receiving treatment in CSOC OOH treatment, CMs will follow an established DD Roundtable process, which is referenced in Section 7.

CMOs are expected to collaborate and communicate with local DDD representatives in their communities on a system level. This may involve DDD representation on the local CIACC, as well as establishing ongoing, routine communication with local DDD staff and an understanding of the available DDD supports, services, and processes.

More information is available in the Protocol for Transitioning Youth with I/DD to DHS/DDD.

X. Adult Mental Health

The Division of Mental Health and Addiction Services (DMHAS) is responsible for the development, coordination, and operational support of a comprehensive mental health and addiction services system.

DMHAS operates four psychiatric hospitals, three regional hospitals, and a forensic center. Specialized services for geriatrics, dually diagnosed, hearing impaired, and other co-occurring conditions are also provided at one or more of the four psychiatric hospitals operated by DMHAS.

DMHAS oversees the provision of a broad range of community mental health and addiction services throughout the state, and contracts with various entities to provide and support community-based prevention, early intervention, treatment, education, and recovery services, including for at-risk and special populations. More details regarding DMHAS supports, services, and processes can be found at <http://www.state.nj.us/humanseservices/dmhas/home/>.

Some DMHAS services, such as psychiatric screening, adult county and state inpatient psychiatric units, provide intervention for youth or young adults with which the CMOs will need to coordinate for youth who need those intensities of services. See above for more information on coordination and collaboration with screening centers.

If a young adult involved with the CMO is admitted to a county or state psychiatric hospital, CMs should convene an Emergency CFT to address the emergent needs of the youth and family. Once a youth is admitted, CMs are required to visit the youth, maintain contact with the family, and hold CFTs, which include hospital representatives, as driven by need. County and state psychiatric hospitals are acute in nature, and transition planning should be done with a sense of urgency to ensure that as soon as appropriate, the youth transitions to the intensity of service that meets the youth's needs.

CMOs encourage county and state psychiatric hospitals to coordinate transition planning for young adults involved with the CMO, and to participate in collaborative planning meetings and/or the Adult Mental Health System Review Committee.

For youth transitioning to adulthood, if the CFT determines that the youth would benefit from ongoing mental health services, the CFT has a responsibility to assist the young adult in linking him/herself with the appropriate community resources and services. Planning for the youth's transition to adult mental health services should begin before the youth turns 18, though the CSOC can remain involved with the young adult up until the youth turns 21, depending on the needs of the young adult.

Routine collaboration and problem solving with adult mental health system providers happens on the local level. CMOs are expected to develop pathways of communication and collaboration with local DMHAS representatives and mental health and substance use treatment providers in their communities. This may involve including DMHAS representatives and providers in the local CIACC, as well as establishing ongoing, routine communication with local staff and an understanding of the available supports, services, and processes at the local level. For a listing of County Alcohol and Drug Abuse Directors and County Mental Health Administrators go to <http://www.state.nj.us/humanservices/dmhas/home/admin/>. A listing of Mental Health Board contact information is located at this site as well. For a listing of County Human Services Directors go to <http://www.state.nj.us/dcf/providers/resources/county/>. For a

listing of Human Service Advisory Councils go to <http://www.state.nj.us/dcf/providers/resources/advisory/> .

XI. Educational Systems

Education is a critical component of a youth's life. The educational system begins serving youth at age 3 when the youth is diagnosed with a learning disability and/or intellectual or developmental disability. It is critical that the CFT understands the youth's educational needs including the youth's classification/accommodation status. CFTs are expected to engage with the school, collaborate with appropriate school personnel, and determine how the school will be involved with the CFT. Including school personnel on the CFT allows the team to help the family advocate for all available appropriate supports and services to maintain the youth in the least restrictive educational setting.

Information regarding the state level Department of Education programs and resources can be located at <http://www.state.nj.us/education/>

The Office of Special Education ensures that students with disabilities receive appropriate educational services to achieve standard learning goals. The office monitors delivery of special education programs, provides mediation to parents and school districts and funds learning resource centers that provide schools and parents with information. The office also plans and implements program and personnel development activities in areas such as implementing the least restrictive environment provision, planning the transition of students with disabilities from school to adulthood, planning programs and services for preschool children with disabilities, developing IEPs and accessing individual rights and entitlements. Further information regarding this office can be found at

<http://www.nj.gov/education/specialed/overview.shtml>..

The McKinney-Vento statute outlines resources available to youth facing homelessness with regards to ensuring education entitlement remains available to them. More information on the McKinney-Vento statute can be found at: <http://www.nj.gov/education/students/homeless/sites.htm>

For more information on educational resources for homeless youth, visit <http://www.state.nj.us/education/students/homeless/> .

One way CMOs can collaborate with school systems is through Educational Partnerships, which are coordinated by CIACCs. Educational Partnerships are alliances between local school districts and local agencies that serve youth and families. These partnerships provide cross system training and help direct resources and services from the NJ DCF and other sources to families in need. They serve as a forum for local school personnel, DCF staff, and local service providers to cross train throughout the school year, and to help systems understand how they fit together in the local system of care to support youth and families. Training programs teach participants about services and resources available from DCF, local schools, and other agencies. Each partnership is supported by a locally maintained web portal that contains archived training materials, up to date resource links, and contact information. CMOs

participate in Educational Partnerships through attendance, presentation of materials, and collaboration.

CMOs can collaborate with the Council for Young Children through the Division of Early Childhood Education (DCEC). DECE enhances social, emotional, physical, and academic development of New Jersey's children -- preschool through third grade -- by providing leadership, resources, and professional development in support of high-quality early childhood programs within a comprehensive, collaborative program. For more information, see <http://www.nj.gov/education/ece/>.

XII. Early Childhood Services and Supports

There are multiple supports available for young children under the age of 5. CMO staff should be familiar with the supports and services available in their communities, and how to access them. Common services available to youth under the age of 5 are listed below.

Early Intervention System

The New Jersey Early Intervention System (NJEIS), under the Division of Family Health Services, implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. EIS provides services for infants and toddlers, age birth to three years of age, with developmental delays and disabilities, and their families.

Services include assistive technology services/devices; audiology services; developmental intervention; family training, counseling and home visits; health services; nursing services; nutrition services; occupational therapy; psychological services; social work services; speech and language therapy; vision services; and other early intervention services. For more information, see <http://nj.gov/health/fhs/eis/index.shtml>.

Early Childhood Services

DCF offers Early Childhood Services which are geared towards families with children ages birth to six. Information on these supports is located at <http://www.state.nj.us/dcf/families/early>.

XIII. Traumatic Loss Coalition (TLC)

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers University Behavioral Health Care is a youth suicide prevention program funded by CSOC.

TLC is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. The dual mission of TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident, and illness. This is accomplished through county, regional, and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. The purpose is to ensure that those working with youth from a variety of disciplines and programs have up-to-date knowledge about mental health issues, suicide prevention, traumatic

grief, and resiliency enhancement. Since its inception, TLC has trained thousands of individuals with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey.

TLC has operated as a county-based collaborative since the year 2000 with a TLC Coordinator in each county. The Coordinators provide meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers, and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. The educational speakers are experts in topics related to the needs of youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post-Traumatic Stress Management (PTSM), Psychological First Aid (PFA), Classroom, Culture, and Community Based Intervention (CBI), and Traumatic Incident Intervention (TII) trainings are provided for members of these teams.

TLC has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss.

CMO should be aware of TLC as a resource and coordinate with local TLC Coordinators. CMOs should encourage TLC Coordinators to participate in local CIACC meetings. Additional information on TLC and a list of TLC Coordinators go to <http://www.ubhc.rutgers.edu/tlc/>.

XIV. Division of Vocational Rehabilitation Services (DVRS)

DVRS provides a wide range of individualized services to assist persons with disabilities to prepare for, obtain, and/or maintain employment consistent with their strengths priorities, needs, abilities, and capabilities. Specific services include vocational assessment, counseling, guidance, job placement, education and vocational training, and other services based on an individual's need to achieve employment. For further information on DVRS, please see http://careerconnections.nj.gov/careerconnections/plan/foryou/disable/vocational_rehabilitation_services.shtml

CMOs should be familiar with their local DVRS office. CFTs can coordinate a referral to DVRS as part of the planning process for young adults 18 and above who have a disability to explore vocational and education options as they transition into adulthood. Any supports identified through DVRS can be incorporated into the CFT to assist the CFT in identifying meaningful work and/or gainful employment for the young adult.

XV. Division of Disability Services (DDS)

DDS provides a single point of entry for those seeking disability related information in New Jersey. DDS works to streamline access to services that promote and enhance independent living for individuals with all disabilities by facilitating coordination and cooperation with among local, county and state government agencies. DDS promotes maximum independence and the

full participation of people with disabilities within all aspects of community life. DDS publishes a resource guide called NJ Resources. This resource and a list of supports and services available through DDS, including screening for programs such as the personal preference program, personal assistance services, and MLTSS, can be found at: <http://www.state.nj.us/humanservices/dds/about/>

CMOs can access DDS for information and access to resources for youth with disabilities who may be eligible for supports and services offered by DDS.

Section 9: Finance and Billing

I. NJ FamilyCare Funding and Billing Practices

The CMO bills for their services through DMAHS's fiscal agent, Molina. For further information on Billing Procedures, see NJMMIS Newsletters and Alerts at <https://www.njmmis.com/documentDownload.aspx?fileType=076B9D7D-96DC-4C8A-B9CE-BA46F47DDE1F>.

Regulations and billing practices are defined in the NJ FamilyCare regulations at N.J.A.C.10:73 and at N.J.A.C.10:49. Bills are prepared for each eligible youth served on a monthly basis. The CMO bills for the first month that an eligible youth begins receiving services from the CMO regardless of the specific initial date of service. The CMO does not bill for the month that an eligible youth ceases receiving service from the CMO regardless of the specific transition date, as per regulation.

CMOs are required to have systems in place to ensure that all billed care management activities have taken place.

II. Contract Funding and Flex Funding

Additionally, there is funding for services that are not Medicaid eligible which are issued as flex funding. Flex funds allow for flexible options to secure a sustainable plan. Refer to flex fund policy.

Flex funding is provided as a temporary fiscal resource to support the goals and objectives outlined in a family's ISP to assist a youth and/or family to achieve their vision and respond to needs when existing funding sources are absent, restrictive, or unavailable at the appropriate time and natural, informal supports are not available or appropriate. Flex fund spending must be in accordance with the CSOC Flex Fund Policy, which can be found in Appendix G of this document. This policy states that flex funding should be utilized as a resource of last resort to purchase identified services that are unavailable through NJ FamilyCare or any other appropriate federal, state, local, or community based resource. The policy further identifies flex funding as time limited and that Wraparound strategies should be developed based upon the principles of sustainability, building upon identified family strengths, and natural supports to assist families in realizing their vision and achieving their goals.

CMOs are expected to check every expenditure of flex funds against a specific strategy in a family's ISP to ensure accuracy before being paid by financial staff.

The CMO will enter all data required into CSOC's EHR system.

The CMO is committed to spending its funds in a fiscally responsible manner and to comply with the rules and regulations as outlined in the DCF Contract Manuals, CSOC Policies, and NJ Medicaid Regulations.

Other

In addition to Medicaid regulations, CMO's are subject to policies set forth through the DCF Contract Policy and Information Manual (CPIM) and Contract Reimbursement Manual (CRM) at <http://www.nj.gov/dcf/providers/contracting/manuals/>

Section 10: Quality Assessment and Performance Improvement

I. Quality Assessment

The overall goals of CSOC are to keep youth at home, in school, and in the community. The Quality Assessment and Performance Improvement process supports these goals by providing a framework for CMOs to regularly review practices and activities to ensure fidelity to the Wraparound Model, assure adherence to state and NJ FamilyCare regulations, and to make recommendations toward best practices, and review youth and family outcomes within the system.

Performance Improvement is a strengths-based process that fits well into the Wraparound Model. It involves a systematic approach to analyzing current performance and designing, testing, implementing, and monitoring interventions that bridge the gap between the way things are and the way they could be. Quality assessment steers all aspects of Care Management Organization activities including practice, documentation, finance, and policy. All staff play a role in providing families with quality services that support families in reaching their vision.

Quality assessment and performance improvement focus on the processes and their outcomes, not on the people carrying out the processes. It is a mindset, a way of approaching everything that we do to ensure that we're providing the best possible outcomes for youth and families. It is not about finding fault in people, but improving processes. Quality assessment relies on timely, accurate documentation of all Care Management activities.

Quality assessment includes but is not limited to the following:

- Improved clinical outcomes and emotional/behavioral stability
- Improved permanency in community living situations
- Reduced lengths of stay in out of home treatment with an emphasis on successfully transitioning the youth home as soon as possible
- Reduced use of restrictive out of home treatment settings and increased use of more family-like settings
- Reduced re-admissions to acute psychiatric hospitals and CCIS
- Improved crisis management and stability in living situations for families and caregivers
- Improved educational performance and overall social functioning for youth
- Reduction in delinquent behavior among youth involved with services
- Improved access to assessments and evaluations and improved timeliness of service delivery in all settings, including youth in detention centers or juvenile shelters
- Improved satisfaction and increased participation in treatment by families and youth

- Compliance with CSOC's Clinical Services Standards and National Best Practices
- Continuity and management of care, accountability, quality, and transparency of service provision:
 - Timeliness of service plan development
 - Living situation – stability, restrictiveness, appropriateness of setting, multiple movements
 - Cultural, ethnic, and linguistic competency
 - Individual service plan appropriateness
 - Involvement of the youth and family in service planning and delivery
 - Youth and family satisfaction with the services provided

The annual Plan for Quality Assessment and Performance Improvement (QA/PI plan) includes the above elements and must be submitted and approved by CSOC in advance of its implementation. The plan shall include objectives, measures, and outcomes. The QA/PI plan is structured to include the following:

- A detailed set of annual objectives, both external and internal to the CMO, including any objectives required by contract or other CSOC priority and including progress towards the financial benchmarks specified in the CMO's contract
- An implementation plan for proposed assessment and improvement activities to attain the annual objectives, including measurable outcomes and provisions to collect data to establish baselines and demonstrate progress on outcomes
- A timetable for the implementation of all the assessment and improvement activities
- A timetable for the attainment of objectives related to the delineated assessment and improvement activities
- Identification of individuals within the CMO responsible for implementation and objective attainment
- A plan for QA/PI reporting both internally and to CSOC at intervals no less than quarterly

II. Measures of Performance

a. Data Dashboards

CSOC provides the CMO with report known as a Data Dashboard. This report provides several measures through categories addressed as: Access, Utilization, Demographics, and Outcomes. The Dashboard allows for uniform measurement of CMOs on a set of indicators that are established for all CMOs, and allows for comparison to statewide statistics. CMOs, in the course of establishing their QA/PI plans, will be expected to review and utilize measures from the Dashboard as part of their improvement plan. The QA/PI plan shall identify areas where measures fall below the CMO's expectations and Statewide, in order to identify areas for performance improvement measurement and activity.

b. Satisfaction Surveys

CMOs may use a variety of Satisfaction Surveys to determine the level of satisfaction with care management services. There are several different groups that may be surveyed about their satisfaction with CMO, providers and the services received:

- Youth
- Caregivers
- Other team members
- Care Managers about providers and about their work in the CMO
- Providers about their satisfaction with the coordination efforts with the CMO to provide their services.

c. Wraparound Fidelity Index

The Wraparound Fidelity Index is a group of measures offered by the University of Washington, used to assess an organization's level of fidelity to the wraparound model. CMOs may utilize these measures as part of the overall Quality Assessment process. There are several different types of measures available:

- A set of surveys completed by youth, families, team members and care managers that assess the wraparound process during the four phases of wraparound: engagement, planning, implementation and transition,
- A Team Observation Measure (TOM) is a tool used to observe a particular Child Family Team with regard to wraparound principles including strengths- and community-based, family-centered and culturally sensitive service planning and
- A tool that is used to evaluate a community or region with regard to accessibility to and services offered in a community.

III. Unusual Incident Reporting (UIR)

CMOs are required by New Jersey Administrative Order (AO) 2:05 (and addendum), and CSOC Policy to report unusual incidents. Unusual incidents are those incidents affecting the health and welfare of CSOC's youth. A list of reportable incidents and time frames can be found in A.O. 2:05 addendum. DCF manages the reporting of unusual incidents through the Unusual Incident Reporting database, an electronic way of collecting, reporting, and analyzing information about incidents that occur in DCF contracted programs. Submitting of UIR, does not take the place of reporting an allegation of suspected abuse or neglect to the State Central Registry (SCR). CMOs are required to identify specific persons responsible for inputting UIR's reports into the electronic database.

CMOs are not expected to investigate incidents that occur in other settings (i.e. out of home treatment programs), however they are expected to report them as they become aware of them. CMOs are expected to coordinate with the primary investigating agency as necessary. Follow

up reports will include information based on CMO's communication with the agency in which the incident occurred.

CMOs shall review all their UIRs no less than annually, and, in consultation with CSOC, determine the necessity of including a quality improvement plan/objective in QA/PI Plans based on their review.

See <http://www.state.nj.us/dcf/about/divisions/opma/risk.html> for links to the Administrative Orders, CSOC UIR Policy, UI category list, contact information for the DCF UIR Coordinator, and the initial and follow report forms.

IV. System Review (SR)

The SR process is an in depth review process, designed to assess the CSOC's strengths and areas for improvement in two categories; Youth and Family Status and System Performance. The Youth and Family Status section focuses on outcomes for youth and families as a result of their involvement in the Wraparound Model, either through the CFT process or through MRSS services. The System Performance section focuses on the system's fidelity to the Wraparound Model and the CFT process. The System Review Tool (SRT) is used to assess the "what" of CSOC practice and narratives and Next Steps documents are used to explore the "why" of CSOC practice.



Care Management Organization Policy Manual

APPENDICES

Appendix A: Family Friendly Language

Language Is Important



Appendix B: Language of CSOC

Language Is Important

Language of CSOC

- Children, youth, young adult
- Parents, caregivers
- Treatment/Care
- Engagement
- Transition
- Missing
- Therapeutic leave

Not the Language of CSOC

- Clients, Case, Consumer
- Mom and Dad
- Placement
- Not Motivated
- Close, Terminate
- Runaway
- Home visits

Appendix C: Practice Guidelines for CMOs Serving Youth with Intellectual and/or Developmental Disabilities and Serious Behavioral Challenges

The purpose of these practice guidelines is to delineate how CMO's can leverage and integrate services for these youth within the existing CSOC model and use of Wraparound values and practices.

Practice Guidelines:

Youth with intellectual and/or developmental disabilities (I/DD) frequently present with a multitude of needs that surpass the scope of traditional behavioral health services requiring a more comprehensive service plan that addresses the youth's educational, family, social, recreational, emotional health, behavioral health, and physical health needs. Care management will serve a pivotal role for youth and families to access all essential services and to achieve optimal benefit from these services by periodically assessing youth's needs and coordinating with other service entities. The NJ Children's System of Care (CSOC) integrated service model will effectively apply Wraparound principles to ensure that youth with I/DD and serious behavioral challenges receive the necessary supports and services to remain at home in the least restrictive setting. CMO shall function as the central care management entity for I/DD youth with behavioral challenges who require intensive in home services such as IIH ABA therapy (BCBA and Behavioral Supports).

The CSOC shall offer Intensive In-Home (IIH) services which encompass Applied Behavior Analysis (ABA) treatment as part of a comprehensive service plan for youth meeting the eligibility and clinical criteria for the service. IIH will provide an intensive therapeutic service to youth with significant behavioral challenges in the home and community settings. IIH ABA services are geared to augment those ABA services already being provided in the school and other settings available in the community; they do not supplant existing services. Additionally, the CSOC will offer less intensive individual behavioral supports to I/DD youth in the home and community settings for youth who require primarily supportive services. For youth with I/DD and co-morbid mental health disorders, the CSOC will offer additional services to include natural supports, non-medical transportation and respite.

Care Management Organizations shall use the guidelines described below as an operational model to ensure a consistent approach to working with I/DD youth and families to achieve optimal benefit of supports and services while ensuring considerate use of available resources. The complexity of the needs of youth with Developmental Disabilities and behavioral challenges requires a systematic process of needs assessment, collaboration with other entities, referring to appropriate community and specialized resources, supporting family capacity, and monitoring effectiveness of services. It is essential for CMO's to communicate realistic expectations about these services which are not a guarantee and are based on the youth's and family's need and availability of resources.

Assessment

CMO's shall conduct comprehensive assessment of youth and family to identify current needs and strengths

- ✓ Assessment shall address how the youth is functioning in the various home, school, and community settings
- ✓ Assessment shall identify those behaviors most critical pertaining to youth's safety
- ✓ Assessment shall identify those behaviors posing risk for potential out of home or acute care services
- ✓ Assess impact of the youth's behaviors on all family members including siblings
- ✓ CMO's shall use the IMDS Strength & Needs Assessment and DD Module, or other CSOC required IMDS tools for recording assessment findings
- ✓ Refer to specialized developmental screening and assessment for diagnostic determination, when indicated
- ✓ Identify current providers and services being utilized or made available
- ✓ Assessment shall include determination of past service history and effectiveness of service
- ✓ Review of prior treatment records and existing evaluations
- ✓ Assist family in completing NJ Medicaid application if youth is not already eligible

Collaboration

CMO's shall collaborate with youth's school, system providers, and community providers

- ✓ Initiate collateral contacts and collaborate with youth's school personnel (ABA provider, Child Study Team, teacher) to assess youth's functioning, determine services presently being offered, and additional service needs
- ✓ CMO shall invite and engage school personnel and existing providers as part of the Child/Family Team Meeting for I/DD youth requesting meeting at the school, when possible, to obtain current information pertaining to youth's current functioning and services (including ABA therapy, response to treatment)
- ✓ CMO shall inquire whether the youth is receiving ancillary services, such as OT, PT, Speech & Language therapies through the school
- ✓ School based services should be fully explored, utilized and exhausted prior to consideration for IIH services. Child/Family Team Meeting shall include the attendance and involvement of the youth current behavioral health providers who are implementing in-home or in-office ABA types of behavioral supports
- ✓ Provide resource information for families to understand educational rights, processes, and services, such as SPAN, when indicated
- ✓ Integrate the ABA crisis plan in the development of the CMO crisis plan

Referral

CMO's shall identify, utilize, and expand knowledge and use of community resources and array of services geared to youth and families with developmental disabilities

- ✓ Availability of third party liability (TPL) insurance coverage must be determined
- ✓ If youth has TPL, care management must assist the family in understanding coverage benefits and in obtaining services through insurance
- ✓ Care management shall locate existing community based services that offer ABA and related specialized treatment through community mental health and specialized children's hospitals and agencies office based services
- ✓ Care management shall assist families in identifying treatment resources for psychotropic medication and medication monitoring, where required
- ✓ Care management shall assist families in locating and accessing medical services available through TPL, Medicaid , and other resources
- ✓ Care management shall delineate school and community based services on the Individualized Service Plan (ISP) as part of the comprehensive service plan
- ✓ Assist family in completing the DD Eligibility Application if not already DD eligible
- ✓ Care management shall request IIH services through the CSA after exhausting all other resources
 - Youth is not covered by TPL
 - School services are optimized for youth to receive maximum benefit.
 - Specialized community based services in the office setting are not available or accessible for the family
 - Youth demonstrates current maladaptive safety behaviors and or potential for future out of home placement or acute care
 - Youth has been determined DD eligible
- ✓ Child/Family Team Meeting shall explore and identify formal and informal community resources to address social and recreational service needs such as:
 - Social Skills Groups
 - Specialized Social/Recreational Activities (therapeutic horseback riding, therapeutic swim, creative arts therapies: art, music, dance, movement)
 - Structured after-school and week-end programs
- ✓ Child /Family Team shall explore support needs for the family
 - Provide referrals or resources for siblings impacted by the youths behaviors
 - Refer parent/guardians to support groups available through the Family Support Organizations, and other advocacy groups such as Family Resource Network, and Autism NJ
- ✓ Assist family in identifying natural supports, such as other family members, relatives, neighbors, friends, and community members who may be interested in providing respite or care, if given coaching or training to address special needs
- ✓ Encourage family to complete the Family Support Application through the CSA for any available respite and or recreational services

Monitor Outcome Effectiveness

CMO's shall monitor effectiveness of the Comprehensive Service Plan which identifies all services, resources, and interventions

- ✓ CMO's shall initiate regular contact with the youth and family to elicit progress, barriers and or challenges in accessing care and services
- ✓ CMO's shall maintain regular collateral contact with providers working with the youth and family to inquire about participation and progress
 - School ABA services should be coordinated closely with any other CSOC provided ABA behavioral health service for best synergistic results
- ✓ CMO's shall convene regular Child/Family Team meetings to include school personnel, school and community based ABA providers, and other community service providers, and natural supports
- ✓ CMO's shall propose holding the Child Family Team meetings at the schools to increase access to ABA provider in the school setting
 - Reinforce that school system has primary educational responsibility to assess youth's strengths and needs and provide behavioral (ABA) interventions as well as ancillary services (OT, PT, S<) when indicated
- ✓ Utilize the Child/Family Team Meeting as the forum to exchange information about service delivery and effectiveness
 - Communication to share relevant information pertaining to the current services provided, share lessons learned (what interventions have been helpful, what has not been helpful, etc).
 - Assess fidelity to use of evidenced based practices
 - Consider effectiveness of current evidenced based practice and alternatives, as needed
 - Identify and address any barriers or challenges the youth and or family may be experiencing
 - Monitor whether providers are staffing and conducting services as authorized or needed
 - Monitor utilization of hours to ensure allocation for potential crisis within authorization period
 - Monitor to ensure providers do not exceed the number of units within the 90 day period as additional units will not be authorized
 - Determine need for any other specialized assessments in the event treatment is not progressing as expected
- ✓ Support holistic approach to treatment and Integration of school, medical, TPL, and behavioral therapies
 - Avoid duplication, multiple providers
 - Identify and address any contradictory approaches and or aversive interventions
 - One child at a time receiving in home I/H
- ✓ Assess and monitor progress

- Examine whether the family is effectively implementing safety and Family Crisis Plans
- Assess whether youth is demonstrating progress in acquiring new skills and replacement behaviors
- Assess whether youth shows increasing involvement and participation in the community
- ✓ Determine whether family and siblings have received necessary supports and resources both formal and informal
- ✓ Review and understand the Behavior Support Plan that is developed and submitted by the IIH ABA provider and encourage communication between youth, family, and ABA providers
- ✓ Convene Child Family Team meetings following crisis events to determine whether the Family Crisis Plan and or Behavior support Plan needs to be updated
- ✓ Submit updated IMDS Strength & Needs with associated DD modules or other CSOC required IMDS tools and ISP's to the CSA at required intervals
- ✓ The CSA reviews for appropriate and effective care
 - Youth meet clinical criteria for intensity of services requested
 - The Individualized Service Plan (ISP) addresses identified needs
 - The ISP reflects adequate collaboration with and services by all associated entities
 - Care is monitored to ensure continued length of stay is substantiated by youth benefitting from services
 - Services and formal supports are faded at appropriate intervals and service plan relies increasingly over time on natural supports and family strengths

Communicate Expectations

CMO's shall continuously communicate expectations pertaining to values and access of CSOC services to youth, families, and providers comprising the Child Family Team for promoting community integration, supporting dignity of youth and family capability

- ✓ IIH is an intensive, time limited service with maximum number of units
 - Time limited services create an intensity in the delivery of therapeutic service model, rather than deteriorate to respite services over time
 - Reinforce expected time frames for achieving service planning objectives
 - Greater probability for achieving desired outcomes
- ✓ Families must consent to proposed services authorized by the CSA and understand they may request changes in the Behavior Support Plan and ISP
- ✓ Families must agree to participate and assume responsibility for learning and practicing interventions as outlined in the Behavior Support Plans

- ✓ Service hours start higher, with built in decrease in hours to anticipate need to fade away services, enhance family competencies, diminish dependency on provider
 - IIH supports community integration by having realistic goals which can be accomplished in reasonable time frames
 - IIH supports family competencies by decreasing or fading services and allowing for more family implementation of the behavioral support plan and transfer of skills to the youth and family/caregiver.
- ✓ IIH will terminate but the youth may continue receipt of ABA and other specialized treatment in the school, as required, and may transition to office based settings for alternate evidenced based treatment models conducted by other specialized providers as needs may dictate
- ✓ Determine the criteria for when CMO is no longer needed and CMO is transitioned out
- ✓ Increase reliance for family and youth on informal and natural supports

Appendix D: Acronyms

Acronym	Translation
A	
AA	Alcoholics Anonymous
AAMFT	American Association of Marriage and Family Therapists
AAMR	American Association of Mental Retardation
AAP	Assertive Aftercare Program
AATOD	American Association of the Treatment of Opioid Dependence
ACA/ACOA	Adult Children of Alcoholics
ACSES	Automated Child Support Enforcement System
ACT	Assertive Community Treatment
ADA	American Disabilities Act
ADADS	Alcohol and Drug Abuse Data System
ADAU	Alcoholism and Drug Abuse Unit
ADD or ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
ADM	Alcohol, Drug Abuse, or Mental Disorders
AFDC	Aid for Families with Dependent Children
AG	Attorney General
AH	Auditory Handicapped
AIA	AIDS Initial Assessment
AIDS	Acquired Immune Deficiency Syndrome
AI	Alcohol Issues Index
AL-ANON	Support group for family members of alcoholics
ALA-TEEN	Support group for teenage alcoholics
AMA	Against Medical Advice
	American Medical Association
AMTA	American Methadone Treatment Association
ANA	American Nurses Association
AO	Administrative Order
AOB	Acting Out Behavior Scale
AOC	Administrative Office of the Courts
AOD	Alcohol and Other Drugs
AODV	Alcohol, Other Drugs, and Violence
AOS	Addiction Only Services
AOTU	Adolescent Offenders Treatment Unit
APA	American Psychiatric Association
	American Psychological Association
APS	Acute Psychiatric Services
	Adult Protective Services
APCBNJ	Addiction Professionals Certification Board of New Jersey
APHS	American Public Health Association
API	Alcohol Problem Index

Acronym

Translation

APN	Advanced Practice Nurse
ARBD	Alcohol Related Birth Defects
ARND	Alcohol Related Neurological Disorder
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorders
ASFA	Adoption and Safe Families Act
ASI	Addiction Severity Index
ASPD	Antisocial Personality Disorder
ATOD	Alcohol, Tobacco, and Other Drugs
ATOC	Addiction Technology Transfer Center
AUDIT	Alcohol Use Disorders Identification Test
AUS	Alcohol Use Scale
AWOL	Absent Without Leave (elopement)

B

BAC	Blood Alcohol Content
BAI	Beck Anxiety Inventory
BAK	Before and After Kindergarten Program
BA	Behavioral Assistant
BDI	Beck Depression Inventory
BED	Binge Eating Disorder
BG	Block Grant
BI	Brief Intervention
BID	Twice a day (medication)
BPD	Borderline Personality Disorder
BPS	Biopsychosocial Assessment
BRFSS	Behavioral Risk Factor Surveillance System
BSI	Brief Symptom Inventory
BSI-18	Brief Symptom Inventory - 18
BSS	Block Grant Support Services
BTOS	Behavioral Therapy Outcomes Study

C

CA	Cocaine Anonymous
CAAPE	Comprehensive Addictions and Psychological Assessment
CAC or CADC	Certified Alcohol Counselor/Certified Alcohol & Drug Counselor
CAFAS	Child/Adolescent Functional Assessment Score
CAGE	Cut Down, Annoyed, Guilty, Eye Opener
CAM	Capable Adolescent Mothers
CAMI	Chemically Abusing Mentally Ill Chemically Addicted Mentally Ill
CANS	Child and Adolescent Needs and Strengths
CAPU	Children/Adolescent Psychiatric Unit
CARF	Commission on Accreditation of Rehabilitation Facilities

Acronym	Translation
	Council on Accreditation of Residential Facilities
CART	Case Assessment Resource Team
CAS	Child Activity Scale
	Center on Alcohol Studies (Rutgers University)
CASA	Center on Addiction and Substance Abuse (Columbia University)
	Court Appointed Special Advocate
CASI	Comprehensive Adolescent Severity Index
CASIA	Comprehensive Addiction Severity Index for Adolescents
CAT	Crisis Assessment Tool (an IMDS tool)
	Comprehensive Assessment Tool (DD)
CB	Crisis Bed
CBO	Community Based Organization
CBOSS	County Board of Social Services
CBT	Cognitive Behavioral Therapy
CBVI	Commission for the Blind and Visually Impaired
CCC	Children's Coordinating Council
CCGNJ	Council on Compulsive Gambling of New Jersey
CCIS	Children's Crisis Intervention Services
CCISC	Comprehensive Continuous Integrated System of Care
CCM	Clinical Case Management
CCR	Community Care Residence
CCR&R	Community Child Care Resources and Referral System
CCS	Certified Clinical Supervisor
CD	Chemical Dependency
CDA	Chemical Dependency Associate
CDC	Centers for Disease Control and Prevention
CDDR	Customary Drinking and Drug Use Record
CDS	Controlled Dangerous Substance
C&E	Consultation and Education
CEAS	Comprehensive Emergency Assistance Program
CEATTC	Central East Addiction Technology Center
CECEP	Center for Early Childhood Education Program
CFS	Child Functioning Scale
CFSR	Child Family Service Review
CFT	Child Family Team
CH	Communication Handicapped
CHES	Certified Health Education Specialist
CHLP	Community Health Law Project
CHSAC	County Human Service Advisory Council
CIACC	Children's Inter-Agency Coordinating Council
CINA	Clinical Institute Narcotic Assessment
CIS	Crisis Intervention Specialist (MRSS worker)
CIWA	Clinical Indicators of Withdrawal Assessment
	Comfort, Ideas, Worries, or Anger

Acronym	Translation
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol, Revised
CM	Care Manager Care Management
CMHC	Community Mental Health Center
CMHS	Center of Mental Health Services (SAMHSA)
CMIF	Case Manager Intake Form
CMO	Care Management Organization
CMS	Contract Management System
CN or CON	Certificate of Need
CNACL	Certificate of Need and Acute Care Licensing
CNS	Central Nervous System
COA	Children of Alcoholics Council on Accreditation of Children and Family Services
COBRA	Consolidated Omnibus Reconciliation Act
COC	Continuum of Care
COD	Co-Occurring Disorders
CODA	Co-Dependents Anonymous
CODC	Co-Occurring Disorders Capable
CODE	Co-Occurring Disorders Enhanced
COLA	Cost of Living Adjustment
COSA	Children of Substance Abusers
CPAC	Community Planning and Advocacy Center
CPC	Child Partial Care
CPR	Counter Performance Report
CPRB	Child Placement Review Board
CPS	Case Practice Specialist Certified Prevention Specialist Child Protection Specialist Child Protective Services
CPSAI	Child Protection Substance Abuse Initiative
CQI	Continuous Quality Improvement
CR	Conditional Release
C&R	Coordination and Review
CRA	Community Reinforcement Approach
CREMU	Complaint and Reportable Event Management Unit (DAS)
CSA	Contracted Systems Administrator Controlled Substances Act
CSAP	Center for Substance Abuse Prevention (SAMHSA) Corrections Substance Abuse Program
CSAT	Center for Substance Abuse Treatment (SAMHSA)
CSOC	Children's System of Care
CSS	County Service Specialist
CST	Child Study Team
CSWE	Council for Social Work Education

Acronym

Translation

CTU	Crisis Triage Unit
CUD	Cannabis Use Disorders
CWA	County Welfare Agency
CWLA	Child Welfare League of America
CWR	Child Welfare Reform
CY	Calendar Year
CYSC	County Youth Service Commission
CYT	Cannabis Youth Treatment

D

DACS	Division of Aging and Community Services
DAG	Deputy Attorney General
DAI	Drug Abuse Index
DAP	Data Assessment Plan (progress note type)
DARE	Drug Awareness Resistance Education
DAS	Division of Addiction Services
DASIS	Drug and Alcohol Services Information System
DAST	Drug Abuse Screening Test
DAWN	Drug Abuse Warning Network
DBT	Dialectical Behavior Therapy
DCA	Department of Community Affairs
	Division of Consumer Affairs
DCBHS	Division of Child Behavioral Health Services (now CSOC)
DCF	Department of Children and Families
DCI	Drug Court Initiative
DCP	Diversion Control Plan
DCP&P	Division of Protection and Permanency (formerly DYFS)
DCSOC	Division of Children's System of Care
DD	Developmentally Disabled/Delayed
	Developmental Disability/Delay
DDD	Division of Developmental Disabilities
DDHH	Division of Deaf and Hard of Hearing
DDMI	Developmental Disabilities/Mental Illness
DDS	Division of Disability Services
DEA	Drug Enforcement Administration
DES	Disorders of Extreme Stress
DFC	Drug Free Communities
DFCP	Division of Family and Community Partnerships
DFD	Division of Family Development
DFI	Dyadic Formation Inventory
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DID	Dissociative Identity Disorder (formerly Multiple Personality Disorder)
DII	Drug Issues Index

Acronym	Translation
DIS	Diagnostic Interview Schedule
DISC	Diagnostic Interview Schedule for Children
DISC-R	Diagnostic Interview Schedule for Children - Revised
DMAHS	Division of Medical Assistance and Health Services
DMHS	Division of Mental Health Services
DO	District Office
DOC	Department of Corrections
DOE	Department of Education
DOH	Department of Health
DOL	Department of Labor
DOT	Department of Transportation
DPCP	Division of Prevention and Community Partnerships (now DFCP)
	Division of Parole and Community Programs
DSC	Designated Screening Center
DSM	Diagnostic and Statistical Manual
DTR	Double Trouble in Recovery
DUI	Driving Under the Influence
DUII	Driving Under the Influence Initiative
DUS	Drug Use Scale
DV	Domestic Violence
DVR	Division of Vocational Rehabilitation
DWI	Driving While Intoxicated
DYFS	Division of Youth and Family Services (now DCP&P)
E	
EA	Emergency Assistance
EAP	Employee Assistance Program
EBD	Emotional/Behavioral Disorder
EBP	Evidence Based Practice
ECG	Electrocardiogram
ED	Emotionally Disturbed
EEG	Electroencephalogram
EEOC	Equal Employment Opportunity Commission
EHR	Electronic Health Record
EIP	Early Intervention Program
EMR	Electronic Medical Record
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ES	Emergency Services
ESL	English as a Second Language
F	
FAE	Fetal Alcohol Effects
FANS	Family Assessment of Needs and Strengths (an IMDS tool)

Acronym

Translation

FAPE	Free Appropriate Public Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FCIU	Family Crisis Intervention Unit
FCM	Family Case Management, Superior Court
FDA	Food and Drug Administration
FES	Family Environment Scale
FFS	Fee For Service
FFY	Federal Fiscal Year
FPS	Family Preservation Services
FSO	Family Support Organization
FSP	Family Support Partner
FSS	Family Support Services
FT	Family Team (DCP&P)
FTM	Family Team Meeting (DCP&P)
FY	Fiscal Year

G

GA	General Assistance
	Gamblers Anonymous
G&A	General and Administrative
GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Functioning
GAIN	Global Appraisal of Individual Needs
GAM-ANON	Gamblers Anonymous
GAEP	General Assistance Employability Program
GCADA	Governor's Council on Alcoholism and Drug Abuse
GED	Graduate Equivalency Diploma
GH	Group Home
GLBTQ	Gay, Lesbian, Bisexual, Transgender, Questioning
GMO	Grants Management Officer
GOT	Group-based Outpatient Treatment
GRPA	Government Performance and Results Act
G-RRS GAIN	Recommendation and Referral Summer of GAIN
GS	Guardianship Services

H

HAM-D	Hamilton Rating Scale for Depression
HBID	Health Benefit Identification
HCFA	Health Care Financing Administration
HEPA	Hepatitis A Virus
HEPB	Hepatitis B Virus
HEPC	Hepatitis C Virus

Acronym

Translation

HH	Halfway House
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HHO	Household of One (NJ FamilyCare)
HRSA	Health Resources and Services Administration
HS	At Bedtime (medication)
HSAC	Human Services Advisory Council
HSP	Human Services Police
HUD	US Department of Housing and Urban Development

I

IAIU	Institutional Abuse Investigation Unit
IAP	Individual Assessment Profile
ICC	Inspection, Compliance, and Complaints
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10 th Edition
ICM	Intensive Case Management
ICMS	Integrated Case Management Services
ICOPSD	Individuals with Co-Occurring Psychiatric and Substance Disorders
ICP	Individualized Crisis Plan
ICRC	International Certification and Reciprocity Consortium
ID	Intellectually Disabled
IDD	Intellectually/Developmentally Disabled
IDEA	Individuals with Disabilities Education Act
IDP	Intoxicated Driving Program Individual Development Plan
IDRC	Intoxicated Driver Resource Center
IDU	Injecting Drug User Intravenous Drug User
IEP	Individual Education Program
IFSS	Intensive Family Support Services
IIC	Intensive In-Community
IIH	Intensive In-Home
IMDS	Information Management Decision Support
IMS	Information Management System
IOM	Institute of Medicine
IOP	Intensive Outpatient
IOS	Intensity of Service
IP	Inpatient
IPT	Interpersonal Psychotherapy Model
I&R	Information and Referral
IRTS	Intensive Resident Treatment Services
I-SATS	Inventory of Substance Abuse Treatment Services

Acronym	Translation
ISP	Initial Service Plan Individualized Service Plan Intensive Supervision Program
ISS	Intensive Support Services
J	
JBWS	Jersey Battered Women's Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCC	Juvenile Conference Committee
JFCU	Juvenile/Family Crisis Center
JJC	Juvenile Justice Commission
J-MDT	Juvenile Multi-Disciplinary Team
K	
KIV	Keys to Innervisions
L	
LAAM	Levo-alpha-acetylmethadol
LAC	Licensed Associate Counselor
LACADA	Local Advisory Committee on Alcoholism and Drug Abuse
LCADC	Licensed Clinical Alcohol and Drug Counselor
LCSW	Licensed Clinical Social Worker
LD	Learning Disability (Disabled)
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LMFT	Licensed Marriage and Family Therapist
LOA	Letter of Agreement
LOC	Level of Care
LOCI	Level of Care Index
LOCUS	Level of Care Utilization System
LOF	Level of Functioning
LOS	Level of Service Length of Service (or Length of Stay)
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LSD	Lysergic Acid Diethylamide
LSS-A	Life Satisfaction Scale for Adolescents
LSW	Licensed Social Worker
LTR	Long Term Residential
M	
MA	Methadone Anonymous
MAC	Municipal Alliance Committee
MADD	Mothers Against Drunk Driving

Acronym	Translation
MAOI	Monoamine Oxidase Inhibitors
MAP	Mutual Agreement Program
MASK	Middle After School Kare
MAST	Michigan Alcoholism Screen Test
MAT	Medication Assisted Treatment
MAYSI	Massachusetts Youth Screening Instrument
MBTI	Myers-Briggs Type Indicator
MCH	Maternal and Child Health
MCMI-II	Milan Clinical Multi-Axial Inventory II
MDA	Methylene-dioxy-amphetamine (synthetic psychedelic drug)
MDD	Major Depressive Disorder
MDI	Bayley Mental Developmental Index
MDMA	Ecstasy
MDS	Minimum Data Set
MDT	Multi-Disciplinary Team
ME	Medical Examiner
MedMAP	Medication Management Approach in Psychiatry
MET	Motivational Enhancement Techniques/Therapy
MH	Multiply Handicapped
MHA	Mental Health Association
MHSF-III	Mental Health Screening Form III
MI	Motivational Interviewing
MICA	Mentally III Chemical Abuser
	Mentally III Chemically Addicted
MICD	Mentally III Chemically Dependent
MIDAS	Mental Illness Drug and Alcohol Screening
MIOP	Methadone Intensive Outpatient
MIS	Management Information System
MISA	Mentally III Substance Abuser
MISU	Mentally III Substance Using
MM	Methadone Medication
	Methadone Maintenance
MMPI	Minnesota Multiphasic Personality Inventory
MLTSS	Managed Long Term Supports and Services (NJ FamilyCare)
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mentally Retarded (now ID)
MRSS	Mobile Response and Stabilization Services
MSE	Mental Status Exam
MSW	Masters in Social Work
MTC	Modified Therapeutic Community
MVC	Motor Vehicle Commission
MWE	Modified Work Environment

Acronym

Translation

N

NA	Needs Assessment (an IMDS tool) Narcotics Anonymous Neurotics Anonymous
NAADAC	National Association of Alcoholism and Drug Abuse Counselors
NAC	National Advisory Council
NAMARecovery	National Alliance for Medication Assisted Recovery
NAMI	National Alliance for the Mentally Ill
NAS	Neonatal Abstinence Syndrome
NASADAD	National Association of State Alcohol/Drug Abuse Directors
NASW	National Association of Social Workers
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NETI	Needle Exchange Treatment Initiative
NHA	Nurtured Heart Approach
NI	Neurologically Impaired
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
N.J.A.C.	New Jersey Administrative Code
NJACRF	New Jersey Association of Children's Residential Facilities
NJAMA	New Jersey Association of Mental Health Agencies
NJAMI	New Jersey Alliance for the Mentally Ill
NJ CAT	New Jersey Comprehensive Assessment Tool (DD)
NJCSOCI	New Jersey Children's System of Care Initiative (now CSOC)
N.J.S.A.	New Jersey Statute (Annotated)
NJ-SAMS	New Jersey Substance Abuse Monitoring System
NMFI	National Master Facility Inventory
NMHA	National Mental Health Association
NOMS	National Outcome Measures
NP	Nurse Practitioner
NRC	National Research Council
NSDUH	National Survey on Drug Use and Health
N-SSATS	National Survey of Substance Abuse Treatment Services

O

OAS	Office of Applied Studies
OCA	Office of the Child Advocate
OCAC	Office of Child Abuse Control
OCD	Obsessive-Compulsive Disorder
OCS	Office of Children's Services (now CSOC)
OMT	Opioid Maintenance Therapy
ONDCP	Office of National Drug Control Policy

Acronym	Translation
OOE	Office of Education
OOH	Out of Home Treatment
OOL	Office of Licensing
OP	Outpatient
OPDF	Outpatient Drug Free
OPFT	One Person Family Therapy
OPMH	Outpatient Mental Health
OPRA	Open Public Records Act
OPREIS	Office of Research, Planning, Evaluation, and Information Systems
ORT	Opioid Replacement Therapy
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
OTA	Office of Temporary Assistance
OTC	Occupational Training Center
	Over The Counter (medication)
OTP	Opioid Treatment Program
P	
PAC	Professional Advisory Committee (DAS)
PACADA	Professional Advisory Council on Alcoholism and Drug Abuse
PACT	Program in Assertive Community Treatment
PADDI	Practical Adolescent Dual Diagnosis Interview
PAR	Pre-Authorization Review
PAS	Pre-Assessment Screening
PASA	People Against Spouse Abuse
PBC	Performance Based Contracting
PBM	Performance Based Management
PC	Partial Care
PCP	Phencyclidine
PCR	Psychiatric Community Residence
PD	Personality Disorder
PDQ	Personality Diagnostic Questionnaire
PDR	Physician's Desk Reference
PESS	Psychiatric Emergency Screening Services
PET	Parent Effectiveness Training
PG	Pathological Gambling
PH	Preschool Handicapped
PHI	Protected Health Information
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Perceptually Impaired
PIC	Program Improvement Committee
PIP	Psychiatric Intervention Program
	Program Improvement Plan

Acronym	Translation
P.L.	Public Law
PMO	Program Management Officer
PO	Probation Officer
POMS	Prevention Outcome Management System
POS	Point of Service
	Problem Orientation Scale
POSIP	Problem Oriented Screening Interview/Instrument for Parents
POSIT	Problem Oriented Screening Interview/Instrument for Teenagers
PPC	Patient Placement Criteria
PPO	Preferred Provider Organization
PPR	Provider Performance Report
PRIDE	Parents Realizing Independence, Dignity, and Empowerment
PRISM	Psychiatric Research Interview for Substance and Mental Disorders
PRN	As Needed (medication)
PRS	Protective Services
PT	Physical Therapy
PTI	Pre-Trial Intervention
PTSD	Post-Traumatic Stress Disorder
Q	
QA	Quality Assurance
QCMR	Quarterly Contract Monitoring Report
QSR	Quality Service Review
R	
RADAR Team	Rapid Assessment, Deployment, and Response Team
RBS	Responsible Beverage Service
RDS	Resource Development Specialist
RDTC	Regional Diagnostic Treatment Center
RFP	Request for Proposals
RFQ	Request for Qualifications
	Request for Quotes
RH	Resource Home
RHCF	Residential Health Care Facility
RIASI	Research Institute on Addictions Self-Inventory
RLI	Request for Letters of Intent
RMA	Recovery Mentor Associate
RN	Registered Nurse
ROE	Report of Expenditures
ROI	Release of Information
ROR	Release on Own Recognizance
ROSC	Recovery Oriented Systems of Care
ROW	Recovery On Wheels (mobile medication unit)

Acronym**Translation**

RP	Relapse Prevention
RPT	Relapse Prevention Therapy
RR	Rational Recovery
RTC	Residential Treatment Center

S

SAC	Substance Abuse Coordinator or Student Assistance Counselor
SACC	School Aged Child Care
SACWIS	Statewide Automated Child Welfare Information System
SADAP	State Alcohol and Drug Abuse Profiles
SADD	Students Against Drunk Driving
	Students Against Destructive Decisions
SADS	Substance Abusers with Depression Study
SAF-I/F	Supplemental Assessment Form for Intake and Follow Up
SAF-P	Supplemental Assessment Form – Participant
SAI	Substance Abuse Initiative
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMI	Substance Abusing Mentally Ill
SAPT	Substance Abuse Prevention and Treatment
SAPTBG	SAPT Block Grant
SASSI	Substance Abuse Subtle Screening Inventory
SBI	Screening and Brief Intervention
SBIRT	Screening and Brief Intervention and Referral to Treatment
SBYSP	School Based Youth Services Program
SCHIP	State Children's Health Insurance Program
SCID	Schedule for Clinical Individual Diagnosis
SCL-90-R	Symptom Checklist 90 Revised
SCR	State Central Registry
SCSCN	Services for Children with Special Health Needs
SCSHCN	Services for Children with Special Health Care Needs
SDM	Social Decision Making
	Structured Decision Making
SDS	Symptom Distress Scale
	System Data Set
SED	Seriously Emotionally Disturbed
SEL	Social Emotional Learning
SEOW	State Epidemiological Outcomes Workgroup
SFP	Strengthening Families Program
SFY	State Fiscal Year
SJI	South Jersey Initiative
SLP	Speech and Language Pathologist
SMI	Seriously Mentally Ill
SNA	Strengths and Needs Assessment (an IMDS tool)
SOAP	Subjective, Objective, Assessment, Plan (progress note type)

Acronym	Translation
SOC	System of Care
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
SOGS	South Oaks Gambling Screen
SOMMS	State Outcomes Measurement and Management System
SPAN	Statewide Parents Advocacy Network
SPB	State Parole Board
SPEC	Specialty Beds
SPF-SIG	Strategic Prevention Framework State Incentive Grant
SPMI	Seriously and Persistently Mentally Ill
SPQ	SCID II Personality Questionnaire
SR	Substance Related
SPR	State Performance Report
SPRU	Special Response Unit
SR	System Review
SRC	Systems Review Committee
SRD	Self-Report Delinquency
SRFI	Self-Report Family Inventory
SRU	Special Response Unit
SRTU	Specialized Residential Treatment Unit
SSA	Social Security Administration
	Single State Agency
	State Substance Abuse Agency
SSD	Social Security Disability
SSI	Supplemental Security Income
SSI-SA	Simple Screening Instrument for Substance Abuse
SSRI	Selective Serotonin Reuptake Inhibitor
STCF	Short Term Care Facility
STD	Sexually Transmitted Disease
STEP	Systematic Training for Effective Parenting
STGT	Skills Training Group Therapy
STR	Short Term Residential
STW	School To Work
SU	Service Utilization
SuDS	Supplemental Data Set
SQSP	Specialized Women's Services Program
T	
TAC	Technical Assistance Center
TACE	Tolerance, Angry, Cut-down, Eye-opener
TANF	Temporary Assistance for Needy Families
TAPP	Teenage Parenting Program
TAPS	Technical Assistance Publication Series (SAMHSA)
TASC	Treatment Alternatives to Street Crime
TASE	Tobacco Age of Sale Enforcement

Acronym	Translation
TASI	Teenager Addiction Severity Index
TC	Therapeutic Community
TCUDS II	Texas Christian University Drug Screen II
TEDS	Treatment Episode Data Set
TH	Treatment Home
TID	Three Times a Day (medication)
TIPS	Treatment Improvement Protocol Series (SAMHSA)
TLFB	Timeline Follow-Back Interview
TOPPS-I	Treatment Outcome and Performance Pilot Study 1
TOPPS-II	Treatment Outcome and Performance Pilot Study 2
TP	Transitional Living Program
TQM	Total Quality Management
TRI	Treatment Research Institute (UPenn)
TSR	Treatment Services Review
TTL	Treatment Transition Log
T-TSR	Teen Treatment Services Review
TRH	Therapeutic Resource Home
U	
UA	Urinalysis
UCM	Unified Care Management (now CMO)
UCP	United Cerebral Palsy
UDS	Urine Drug Screen
UFDS	Uniform Facility Data Set
YIRMS	Unusual Incident Reporting Management System
UM	Utilization management
UPPC	Uniform Patient Placement Criteria
U.S.C.	United States Code
USTF	Unified Services Transaction Form
V	
VA	Veterans Administration
VLS	Variable Length of Stay
VOP	Violation of Probation
W	
WAIS-R	Wechsler Adult Intelligence Scale Revised
WCCL	Ways of Coping Checklist
WEI	Work Experience Inventory
WFNJ	Work First New Jersey
WF-SAI	Work First Substance Abuse Initiative
WIC	Women, Infants, and Children
WSA	Women's Set-Aside

Acronym	Translation
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X	
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Y	
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YAP	Youth Advocate Program
YAS	Young Adult Self-Report
YCM	Youth Case Management (now CMO)
YHPS	Youth Happiness with Parent Scale
YRBS	Youth Risk Behavior Survey
YSAC	Youth Services Advisory Council
YSC	Youth Services Commission
YSR	Youth Self-Report
YSS	Youth Satisfaction Scale

Z	
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Appendix E: Behavioral Health Homes

Behavioral Health Homes (BHH) will serve as a “bridge” that connects prevention, primary care, behavioral health care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays).

The current child family teams are to include medical expertise and health/wellness education for the purpose of providing fully integrated and coordinated care for children who have chronic medical conditions, as specified in the BHH Clinical Criteria.

Behavioral Health Homes provide services to children with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family’s satisfaction with care; and, improving the family’s ability to manage chronic illness.

The BHH Core Team will build on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team will constitute the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

Children enrolled in BHH will be screened for depression utilizing the CES-DC (ages 12-17) or CES-D (ages 18-20), (certain exclusions apply, such as youth with active depression or bipolar disorder).

The expansion to the child family team includes:

- a) Nurse Manager-minimum qualifications include an RN License in the State of New Jersey. Responsibilities are inclusive of participation in the Wraparound Model of Care within the Child Family Team as it pertains to the development of self-management health goals for inclusion in the youth’s service plan; facilitate regular contact via phone calls and face to face meetings with youth/family to monitor progress and provide support for the self-management goals included in the service plan; assist assigned families with identifying a primary care provider, specialty providers and ensure all appointments are kept; and, obtain applicable metabolic levels and information for assigned youth from primary care providers, educating youth and families regarding identified conditions. Will conduct chart reviews to monitor management of identified conditions that would be addressed by the BHH.
- b) Health/Wellness Coach –minimum qualifications include a Bachelor’s Degree and 2 years of experience in a related field (e.g. nutrition, health education) Responsibilities are inclusive of participation in the Wraparound Model of Care within the Child Family Team; regular contact via phone calls and face to face meetings with youth/family to monitor progress and provide support for the self-management goals contained in the

youth's service plan; and provide health education specific to chronic conditions of participating youth. Engage assigned children and families in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes. These interventions may include preparing youth and families for appointments, educating youth and families regarding identified conditions and accompanying them to appointments to reduce youth/family apprehension. Participate in transitional care and follow-up planning for assigned youth.

BHH will also provide health and wellness activities for children and their families with the ultimate goal of having children and families develop the skills and ability to actively manage their child's chronic medical condition ("chronic disease management") as well as other behavioral conditions.

DCF's CSOC will support the Behavioral Health Home (BHH) by providing data, technical assistance, training and support. The CSA will authorize and assist the BHH in enrolling eligible children.

The CMO is expected to coordinate with NJ FamilyCare Managed Care Organizations (MCO's).

The work of the CMO will continue to be supported by the CSA who authorizes, tracks and coordinates care and service outcomes (reporting IT and coordination of QM function).

SERVICE DEFINITIONS OF THE BHH TEAM

A. COMPREHENSIVE CARE MANAGEMENT

Service Definition: Care Management is the primary coordinating function of a Behavioral Health Home (BHH). The goal of Care Management is the assessment of child's needs, development of the care plan, coordination of the services identified in the care plan and the ongoing assessment and revisions to the plan based on evaluation of the child's needs. The Care Manager is the Team Leader. The BHH team enhances the existing care management team by providing the medical expertise and support needed to help the child and family manage the qualifying chronic conditions in concert with their behavioral health challenges.

Comprehensive care management services involve:

- a) Assessment and documentation of eligibility for BHH Services.
- b) Development and periodic revision of service plans based on information collected through the assessments, review of records and input from child and family.
- c) Ensuring that implementation of the plan will coordinate access to high quality behavioral healthcare and facilitate access to health care services that are informed by evidence-based practices, facilitate access to preventative services, specialty medical care, dental care, and social services. Children with chronic conditions who require expertise and additional medical support will be delegated to the Nurse Care Manager. Plan will

include child/family's goals and preferences, targeted outcomes, identified service provider, coordination of services, and timeframes for services.

- d) Coordination of the BHH team.
- e) Leading the BHH team in the management of care and the implementation of the service plan.
- f) Convening and leading team meetings with BHH team to review and revise child's service plan periodically and as needed in response to child/family request or other qualifying event, using patient information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators. This information will be brought to the team for review and action.
- g) Developing and implementing an internal Quality Assurance program that aligns with Centers for Medicaid and Medicare Services (CMS) required program measures and is capable of including additional measures as needed.

The following would be performed specifically by the Nurse Care Manager, and/or Wellness Coach:

- i. Nursing assessment.
- ii. Monitoring health risks by coordinating screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.
- iii. Monitoring medications and medical treatments for potentially adverse synergistic effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the child.
- iv. Interfacing with specialty medical services.
- v. Referral for medical, behavioral health or other assessment if necessary.
- vi. Monitoring and reporting on the progress of meeting medical outcomes for child/family satisfaction, health status
- vii. Engaging child/family in monitoring health and wellness.
- viii. Enter and utilize data in electronic health record (CSA) to track progress on key health indicators to help family achieve positive outcome.
- ix. Implementing strategies to ensure improved child/family access to BHH services

B. CARE COORDINATION

Service Definition: Care Coordination services are provided by the Care Manager with support from the Nurse Manager; with the primary goal of implementing the individualized service

plan/plan of care, with active involvement by the child/family, to ensure the plan reflects the child/family's needs and preferences. Care coordination emphasizes access to a wide variety of services required to improve overall health and wellness. Care Managers can be social workers and other trained health care professionals. A license in the health care professions is not required. The Nurse Manager must be properly licensed and credentialed.

Care Coordination services include:

1. Engaging and retaining child/family as active participants in their care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses child/family needs.
4. Reviewing service plans with child and family.
5. Identifying children/families that might benefit from additional care management support.
6. Following up with children and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to community, social and recovery supports.
8. Coordinating and referring to Health Promotion and Wellness activities within the BHH as a member of the BHH Team.
9. Maintaining regular, ongoing contact with the child, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

C. HEALTH PROMOTION

Service Definition: Health promotion activities are conducted with an emphasis on empowering the child/family to improve health and wellness. Whenever possible these activities are accomplished using evidence based practices and/or curriculum, including:

- i. Engaging the child in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
- ii. Providing health education specific to chronic conditions.

- iii. Development, with the child and family, of self-management goals to be included in the service plan.
- iv. Monitoring progress on self-management goals.
- v. Providing support for the self-management goals included in the service plan.
- vi. Providing skill development activities to help the child/family understand and manage the health conditions affecting them.
- vii. Providing support and best practices to help child/family learn the skills necessary for maintaining a healthy lifestyle. For example: learning how to plan nutritious meals, shop for healthy foods, prepare meals, practice mindfulness in eating; plan and implement a program for regular exercise and fitness; proper sleep; avoid or reduce harmful behaviors (e.g., smoking, substance use, overeating, under eating, etc.); maintain personal hygiene and a healthy home, and other health promotion activities.
- viii. Facilitating and engaging child/family in Community Supports: help child/family develop and strengthen family support and other community supports to assist them in recovering from behavioral health problems and other health conditions, and help child/family develop motivation to engage in attitudes and activities that promote health and wellness.
- ix. Ensuring access by providing and/or facilitating transportation to appointments, and by accompanying children on appointments to reduce child/family apprehension. Health Team members also can ensure better coordination with the provider by accompanying children and resolving other concerns that might interfere with access.

D.INDIVIDUAL AND FAMILY SUPPORT SERVICES (INCLUDING AUTHORIZED REPRESENTATIVES)

Service Definition: These services can be delivered by care manager or other members of the BHH team. Services are defined as helping the individual and family recognize the importance of family and community support in recovery, health and wellness, and helping them develop and strengthen family and community supports to aid in the process of recovery and health maintenance.

All services can be offered to the family and the child together or separately, including:

- i. Engaging the family, support system and/or the individual child in services with the goal of ensuring family engagement in supporting the recovery and health maintenance of a child with a chronic condition.
- ii. Identifying family related goals to be included in the service plan.

- iii. Providing family education sessions focused on health education, illness management, illness prevention and wellness activities.
- iv. Linking family members to services needed to improve family stability and overall health such as family therapy and social support services.
- v. Helping children and families learn how to advocate for the services and supports they require. Teaching family members strategies for advocating for their child's and family's wellness needs.
- vi. Encouraging and teaching families strategies for supporting their child's ability to self-manage their treatment and wellness activities.

E. COMPREHENSIVE TRANSITIONAL CARE (INCLUDING APPROPRIATE FOLLOW-UP, FROM INPATIENT TO OTHER SETTINGS)

Service Definition: BHHs provide comprehensive transitional care and follow-up to children transitioning from inpatient care and/or emergency care to the community. Comprehensive transitional care can be provided by the Care Manager or, where the inpatient care is medical in nature, the Nurse Manager.

Comprehensive transitional care is provided for every illness that might require intensive care including:

- i. If the child requires inpatient treatment, the BHH Team will facilitate the children's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the child to their admission, and continuing contact with the child while they are receiving inpatient care.
- ii. If the child receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
- iii. BHH Team members coordinate care and treatment planning with hospital-based and community-based physicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better manage the problems that caused the emergency room/inpatient admission and shift their focus from reactive care to child/family empowerment and proactive health promotion and self-management activities.

- iv. BHH Team members will work with children, family members, community supports, and other providers to address transition problems, as they arise, employing evidence-based motivational strategies to ensure child/family engagement in problem-solving efforts.
- v. BHH will coordinate with the adult system of care to coordinate necessary transitions.

F. REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

Service Definition: Referral to community and social support services involves providing assistance for the child/family to obtain necessary community and social supports. CMOs are well positioned to provide access to needed community supports by virtue of having built partnerships for a collaborative, effective system of care which is executed locally. These services involve:

- a) Engaging child/family for effective referral to community and social supports. Since many children and their families in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging children/families to address critical service needs.
- b) Identifying community and social supports needs such as disability benefits, housing, legal and employment services.
- c) Identifying available and appropriate community and social support services to meet those needs.
- d) Referring to community and social support services and providing the support and/or services needed for child/family to obtain these supports such as arranging transportation, making appointments, and arranging for peers or others to accompany child/family when accessing these supports/services.

Appendix F: Working with Youth with Co-Occurring Behavioral Health and Substance Use Needs

NJ Children's System of Care (CSOC) Practice Guidelines

Working with Youth with Co-Occurring Behavioral Health and Substance Use Needs

Purpose: To provide CSOC system partners with practice guidelines related to adolescents with co-occurring behavioral health and substance use needs. These guidelines promote engagement, comprehensive assessment, effective service planning, and positive outcomes.

Screening:

- ✓ Adolescents at risk should be screened:
 - The screening tool should be brief (10-15 minutes in length) and simple enough that a wide range of health professionals can administer the tool (e.g. CRAFFT).
 - The screening tool should include substance use severity, juvenile justice involvement, mental health history, educational functioning, living situation, and social service agency involvement.
 - If the outcome of the screening tool indicates concerns related to substance use, the adolescent should be referred for a comprehensive assessment.
 - Complete the Substance Use Module when rating the Substance Use dimension in the Strength & Needs Assessment if there is minimally suspicion or indication the youth is using any alcohol, tobacco, illegal drugs, misuse of prescription medication, or the use of any substance for recreational purposes (e.g. inhalation of household products). The module serves as a screening tool to identify youth requiring referral for a substance use assessment.

Comprehensive Assessment:

- ✓ Conduct a comprehensive needs assessment of adolescent and their family:
 - Assess for at high risk behaviors.
 - Assess for potential withdrawal management needs or detoxification management needs which would require immediate medical intervention and, or medical monitoring, specifically related to alcohol, benzodiazepines, narcotics, and opiates.
 - Assess history of use of substances, including over-the-counter and prescription medications, first age of use, and treatment history.
 - Utilize a co-occurring framework (substance use and behavioral health).
 - Consider the adolescent in context of their identified supports including, but not limited to, family, peers, school, and community.

- Assess the adolescent's strengths or resiliency factors, including self-esteem, family, community supports, coping skills, and motivation for treatment.
- Understand the developmental needs of the adolescent and how substance use results in skill deficits in anticipated developmental milestones and tasks and impacts on the physical growth of the youth
- Consider influences of traumatic events such as separation anxiety, physical/sexual abuse, gang involvement, drug/human trafficking, death of a loved one, etc.
- The family **should** be involved not only in the comprehensive assessment process, but also in comprehensive interventions.

Referral:

- ✓ Assess and expand community resources:
 - Utilize existing private insurance resources.
 - Explore substance use treatment resources offered through Children's System of Care (CSOC): <http://www.performcarenj.org/families/find-a-provider.aspx>.
 - Identify peer specialist supports.
 - Identify the SACs (Student Assistance Counselors) within your local school districts.
- ✓ Seek networking opportunities in the community with substance use providers.
- ✓ Utilize the required substance use consents (per 42-CFR Part 2) to communicate and collaborate regularly with substance use providers.

Engagement:

- ✓ Develop the therapeutic alliance to engage the youth:
 - Provide orientation to the youth at the onset of treatment so that they feel comfortable and familiarized with the treatment process/therapeutic alliance.
 - Develop creative ways to engage with adolescents, their family, and members of their treatment team.
 - Minimize adverse impact when changing workers. Consider transitional meetings in order to enable him/her to process the change.
 - Document previous treatment experiences (include both positive and negative). What has worked well before? What has not been effective?
 - Program content should be creative, individualized, and culturally appropriate.
 - If court ordered, leverage collaborative participation by communicating with Court, JJC, and probation on a regular basis.
 - Engage the youth into treatment by utilizing motivational interviewing techniques instead of a confrontational approach to care which may increase anxiety and resistance.
- ✓ Understand the *Stages of Change* and concepts of motivational interviewing:

- Engage the adolescent at his/her current stage of change.
- Remember that denial (adolescent and family) is an integral component of substance use.
- Support the adolescent to develop their 5 C's: competence, character, connections, confidence, and contributions in positive ways.
- Appropriate level of responsibility in the adolescent's own care that encourages him/her to make decisions in coordination with his/her family. Have the adolescent take on new roles that enhance his/her self-confidence and encourages ownership of their treatment and recovery process.

Service Planning:

- ✓ Consider the model of substance use as a chronic disease:
 - Seek medical and psychiatric consultation for pharmacologic interventions.
 - Relapse is an opportunity to learn from and to try a different approach.
 - Anticipate treatment barriers and maintain a persistent and hopeful attitude.
 - Consider medical co-morbidities impacted by substance use.
 - Co-occurring mental health and substance use conditions have potential to exacerbate one another.
- ✓ "Rolling with any potential resistance" is an important concept to remember:
 - Anticipate resistance to treatment recommendations.
 - Remember the plan fails and not the youth.
 - The care plan should be individualized in order to meet the specific needs of the adolescent and his/her family.
 - Strongly encourage continued CMO participation (if involved).
 - Utilize supervision to help change the plan for an individualized approach.
 - Collaborate with treatment team members in order to identify care management needs while in treatment in order to support the youth and family (such as need for transportation, healthy vocational activities, community recovery support, etc.)
 - Collaborate with primary care and substance use providers for routine drug and alcohol testing as is indicated in the care plan.
- ✓ Add helpful support attendees and services to enhance the Child Family Team (CFT) process:
 - Include school representatives such as Student Assistance Counselors (SAC) and other educational partnerships, whenever possible.
 - Apply an integrated approach by addressing all co-occurring needs, including any psychiatric treatment and medication psycho-education to both the youth and family to promote medication compliance.
 - Explore substituting "cool" (sober) and age-appropriate activities that are fun and promote self-esteem to enrich the adolescent's recovery environment.
 - Consider use of positive peer supports for CFT enhancement.
 - For additional support and guidance for parents, encourage involvement of the Family Support Organization (FSO).

- Explore available youth partnerships for additional peer to peer supports to favor recovery.
- ✓ Identify specific strengths of the adolescent that can be used in developing a successful and sustainable treatment plan.
 - Utilize the Substance Use Module of the CANS Strengths and Needs Assessment (SNA) to assist in assessment and treatment planning.
- ✓ Consider additional community referral sources for youth support:
 - Identify peer specialist supports.
 - Family group support.
 - Identify NA/AA, Al-Anon, yoga, mindfulness training, and other group supports.
 - Seek networking opportunities in the community with SU providers.


Family Education:

- ✓ Family members should be encouraged to actively participate in assessment, treatment planning, recovery support services, and clinical activities (including family therapy and other services as identified by the goals and needs of the youth and family).
- ✓ Family Centered Care – Services should be youth and family driven and community based whenever feasible.
- ✓ Educate families about substance use treatment and discourage pulling youth out of treatment prematurely:
 - Anticipate the reasons their youth may seek/has sought premature discharge.
 - Encourage families to “roll with resistance” (understand the stages of change and understand where the adolescent is in terms of their motivation to change).
 - Encourage families to maintain unconditional support throughout the entire treatment process, including during times of resistance and relapse.
- ✓ Educate families about the limitations that substance use providers may have to speak with families:
 - Learn about the parameters of disclosure under 42-CFR Part 2.
 - Ensure that required disclosure consents are signed.
 - Encourage communication through Child Family Team (CFT) meetings.
- ✓ Educate families about the harm to the developing brain and overall perils of today’s drug properties to address minimization by families:
 - Remember, the brain is still developing through age 27 years old.
 - Caution families that substance use may exacerbate psychotic disorders.

References:

- ✓ Know the signs of substance use withdrawal:
 - <http://www.webmd.com/mental-health/addiction/alcohol-or-drug-withdrawal>
- ✓ Learn about Naloxone:
 - <http://www.drugfree.org/newsroom/partnership-naloxone-training-in-new-jersey>
- ✓ Educate others about available life-saving rescue drugs for Opiate overdose:
 - Narcan and take-home Narcan: <http://stopoverdoseil.org/narcan.html>
 - <http://www.state.nj.us/humanservices/providers/grants/rfprfi/RFPfiles/Opioid%20Overdose%20Prev%20RFP%206-25-15%20final.pdf>
- ✓ Remember that adolescent brains are still developing through the mid-20's:
 - Read: The Teen Brain: Still Under Construction: http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/teen-brain_141903.pdf
- ✓ Substance use is a brain disease with behavioral symptoms:
 - https://www.drugabuse.gov/sites/default/files/soa_2014.pdf
- ✓ Be aware of treatment for first episode psychosis (may be accelerated in youth with SU)
 - <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-10-16-2015.pdf>
- ✓ Familiarize yourself with well-written free brochures about substance and adolescents:
 - <http://niaaa.nih.gov/publications/brochures-and-fact-sheets>
 - <http://store.samhsa.gov/list/series?name=Tips-for-Teens>
 - <https://teens.drugabuse.gov/national-drug-alcohol-facts-week/order-free-materials>
- ✓ Explore substance use treatment resources offered through Children's System of Care (CSOC): <http://www.performcarenj.org/families/find-a-provider.aspx>
- ✓ Learn about the parameters of disclosure under 42-CFR Part 2:
 - <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>

Appendix G: Children's System of Care-Flex Funds

 New Jersey Department of Children and Families Policy Manual			
Manual:	CSOC	Children's System of Care	Effective Date:
Volume:			
Chapter:			
Subchapter:			
Issuance:		FLEX FUNDS	

Purpose:

This issuance establishes the underlying principles, expectations, and procedures used to effectively manage flex funds in a manner supportive of the family vision as defined with the context of the goals and objectives outlined in an approved plan of care.

Scope:

This issuance applies to all Children's System of Care (CSOC) entities accessing CSOC flex funds, i.e. Care Management Organizations (CMOs), Mobile Response and Stabilization Service (MRSS) providers, and the Contracted System Administrator (CSA).

Policies:

Flex funds should be used as a temporary fiscal resource to support the goals and objectives outlined in an approved plan of care to assist a child and/or family to achieve their vision and respond to needs when existing funding sources are absent, restrictive or unavailable at the appropriate time and natural, informal supports are not available or appropriate. Utilize flex funds as a temporary recourse to respond to a need or as a preventive strategy or recourse while other sustainable strategies and/or formal, informal and natural resources are explored and utilized in a prudent and cost effective manner.

All CSOC entities should consider the following principles when deciding whether to use flex funds:

- 1) Use flex funds as a resource of last resort to purchase and support identified services that are unavailable through the NJ FamilyCare program, Work First New Jersey (WFNJ) program or any other appropriate federal, state, local or community-based resource. Provide supporting documentation in the plan of care to substantiate the request.
- 2) Develop wraparound strategies based upon the principles of sustainability, building upon identified family strengths and natural supports to assist families in realizing their vision and achieving their goals in a manner that strives to transcend the involvement of care management. Long-term plans with services supported by flex funds are not sustainable.
- 3) Services supported by flex funds should be considered as time limited and reviewed as a part of the ongoing child/family team individual service plan development process or other appropriate planning process to assess the continued use of flex funds and identification of sustainable strategies.
- 4) Work closely with internal business and resource development staff, community resource specialists, system partners, informational and referral resources and DCF contract staff to ensure that all existing funding sources and resources, including insurance and entitlement programs, where appropriate, have been explored and maximized prior to the use of flex funds to support the acquisition of a service or good.
- 5) Flex funds may be available to supplement a child's wardrobe in special circumstances for children entering CSOC's out of home programs. Clothing needs are included in CSOC's out of home programs' per diem rate.
- 6) Use of flex funds to support transportation costs should be a temporary measure unless it is medically necessary. Support transportation through informal and community-based supports wherever possible.
- 7) Flex funds are not available to support unlicensed community-based out of home treatment services or other such unlicensed out of state out of home treatment services.

- 8) Flex funds are not available to supplement existing DCF established rates or fee structures for services.
- 9) Flex funds are not available for capital expenditures, **major** home improvements, repairs, renovations, or other such items.
- 10) Flex funds are not available for vehicle purchases. One-time assistance with car insurance premiums, initial down payments or other monthly household expenses may be considered in lieu of the direct purchase. Consider a referral to a non-profit organization that provides budget planning and financial counseling when utilizing flex funds for such purposes.
- 11) Flex funds are not available to secure credit or a loan or used to satisfy any loans, credit or other legal or financial obligations.
- 12) Flex funds are available to provide temporary family assistance such as assistance with utilities, rent, car repair, health insurance co-pays etc., in order to stabilize an emergent family situation with supporting justification. All such uses of flex funds should be considered within the context of this policy and as part of a plan of care with long-term strategies to link with appropriate community organizations for budget planning, financial counseling, etc. A referral to a non-profit organization that provides budget planning and financial counseling is strongly encouraged when flex funds are utilized for such purposes.
- 13) Flex funds are available to temporarily address a need for a sibling or other family member within the parameters defined in this policy if necessary to stabilize a family situation that affects the well-being of the child or avoid a crisis. Purchase items in a prudent and cost effective manner.
- 14) Flex funds are not available to pay for any hospital-based care.
- 15) All services utilizing flex funds must be authorized by the CSA and delivered under the auspices of an approved plan of care developed by the appropriate CSOC entity and accessed and dispersed using established practice, procedures, and standards.

Key Terms (Definitions):

Contracted System Administrator (CSA) - CSA is CSOC's single point of entry and facilitates service access, linkages, referral coordination and monitoring of CSOC services. The CSA also

maintains CSOC's MIS, which serves as the electronic health record for youth enrolled with CSOC. Information is HIPAA protected and is compliant with 42 CFR Part 2 as appropriate.

Care Management Organization (CMO) - CMOs are county-based nonprofit organizations responsible for face-to-face care management and comprehensive service planning for youth and their families with intense and/or complex needs. CMOs coordinate Child Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and his/her family. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to planning.

Mobile Response and Stabilization Services (MRSS) - MRSS is the CSOC's urgent response service designed to assist in stabilizing youth in their home and community settings. MRSS provides immediate intervention to assist youth and their caregivers in de-escalating behaviors, emotions, and/or dynamics impacting youth life functioning. Interventions are designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains. The initial phase of MRSS can extend for up to 72 hours after the dispatch request and includes de-escalation, assessment and crisis planning services with a focus on youth and family engagement. Based on the youth and family's needs following the 72 hour initial response, MRSS may remain involved with the child and family for up to eight weeks of stabilization management, during which time MRSS staff will coordinate formal and informal services for the youth and family.

CSOC Flex Funding
Reporting Categories

#	Category	Examples of Allowable Services
1	Psychiatric Evaluation	1) psychiatric evaluation 2) medication monitoring
2	Psychological Evaluation	1) psychological evaluations 2) specialized evaluations
3	Therapy Office Based	1) counseling 2) specialized therapy (sex offender, fire setting, abuse victim) 3) art therapy
4	Professional Services	1) therapy not office based 2) partial care program 3) specialized therapy not office based
5	Clothing Allowance	1) clothes 2) clothing allowance
6	Educational/Instructional	1) after school services 2) vocational training 3) educational expenses (teacher, tuition, lessons) 4) parent training 5) work stipend
7	Medical Services	1) medical/health services (physician, dentist, optometrist) 2) medical supplies/equipment
8	Living/Housing Expenses	1) rent payment/rental assistance/rental deposit 2) housing/rental cost (security deposits, realtor fees) 3) home furnishings 4) housing supplies/housekeeping 5) home owner insurance premium 6) room & board for independent living
9	Recreational/Allied	1) recreational class/lesson fee (YMCA memberships, art/music/karate lessons) 2) recreational stipend 3) sporting equipment 4) social recreation
10	Mentoring	1) mentoring services 2) companionship
11	Emergency Housing/Shelter Care	
12	Substance Use Services	evaluations/assessments
13	Transportation	travel expenses (air, taxi, bus, mileage reimbursement, transportation services)
14	Vehicle Expenses	vehicle expenses (insurance, gasoline, DMV charges, auto loans, repairs)
15	Personal Care Assistance	1) grooming (haircuts, grooming supplies, laundry) 2) baby sitting 3) food 4) health insurance premiums
16	Family Assistance	goods/services purchased for family
17	Utilities	1) phone/electrical/gas/oil expenses (services, purchases, back payments, security deposits) 2) shipping fees (postage)
18	Camp	camp (day camp, summer programs/camps)
19	Respite Care	
20	Pharmacy	prescriptions
21	Alternative Community Living	drug/alcohol rehabilitation facilities